Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 12/01/2024 and ending 11/30/2025

A This return/report is for:
- ☐ a multiemployer plan
- ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- ☒ a single-employer plan
- ☐ a DFE (specify) ____

B This return/report is:
- ☒ the first return/report
- ☐ the final return/report
- ☐ an amended return/report
- ☐ a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ ☐

D Check box if filing under:
- ☐ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶ ☐

Part II Basic Plan Information—enter all requested information

1a Name of plan
WENDT INC DBA THE WENDT AGENCY EMPLOYEE HEALTH CARE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 12/01/2024

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
WENDT INC.
THE WENDT AGENCY

105 PARK DR S
GREAT FALLS, MT 59401-3612

105 PARK DR S
GREAT FALLS, MT 59401-3612

2b Employer Identification Number (EIN) 81-0250310

2c Plan Sponsor's telephone number 406-454-8500

2d Business code (see instructions) 541800

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	02/19/2026	ANGELA MOODY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	02/19/2026	ANGELA MOODY
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:

a Sponsor's name WENDT INC DBA THE WENDT AGENCY

c Plan Name WENDT INC DBA THE WENDT AGENCY EMPLOYEE HEALTH CARE PLAN

4b EIN 81-0250310

4d PN 501

5	Total number of participants at the beginning of the plan year	**5**	14
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	14
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	15
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	15
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	15
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	0

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- **(4)** [ ] **DCG** (Individual Plan Information) – Number Attached _____
- **(5)** [ ] **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 1
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 12/01/2024 and ending 11/30/2025

A Name of plan
WENDT INC DBA THE WENDT AGENCY EMPLOYEE HEALTH CARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
WENDT INC.

D Employer Identification Number (EIN)
81-0250310

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
ALLIED BENEFIT SYSTEMS, LLC

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
		L243961	14	12/01/2024	11/30/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			7b	
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	120461
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			10b	0

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

WENDT INC DBA THE WENDT AGENCY EMPLOYEE HEALTH PLAN
CORE VALUE
SUMMARY PLAN DESCRIPTION

GUIDE TO YOUR SPD

The sections of the SPD appear in the following order:

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I. PLAN ADMINISTRATION INFORMATION

Name Of Plan:	WENDT INC DBA THE WENDT AGENCY Employee Health Care Plan ("Plan")
Plan Number:	501
Group Number:	L243961
Plan Year:	12/1/2025 to 11/30/2026
Employer:	WENDT INC DBA THE WENDT AGENCY
Plan Sponsor: (if different than Employer):	WENDT INC DBA THE WENDT AGENCY
Plan Sponsor ID No. (FEIN)**:**	81-0250310
Plan Administrator (Employer, unless designated otherwise)	WENDT INC DBA THE WENDT AGENCY 105 PARK DR S GREAT FALLS, MT 59401
Third Party Administrator ("TPA"):	Allied Benefit Systems, LLC PO Box 211651 Eagan, MN 55121 (888) 306-0905 www.alliedbenefit.com
Funding Source:	Administration expenses and Plan benefits are paid by the Employer directly through the WENDT INC DBA THE WENDT AGENCY's general assets
Type Of Plan:	Self-funded group health plan administered by contract with TPA

This is not an insured benefit plan. The Plan benefits are self-funded by the Employer. The Employer is solely responsible for all coverage determinations and Plan benefit payments.

The TPA has been hired to process claims under the Plan. The TPA does not serve as an insurer, but merely as a claims processor. Claims for benefits are sent to the TPA. It processes the claims, then requests and receives funds from Employer to pay the claims, and makes payment on the claims to hospitals and other providers. The Employer is ultimately responsible for providing Plan benefits, and not the TPA. The TPA does not insure the Plan and is not responsible for funding Plan benefits.

Agent For Service Of Process:	WENDT INC DBA THE WENDT AGENCY 105 PARK DR S GREAT FALLS, MT 59401

II. BENEFIT SUMMARY

PLAN EFFECTIVE DATE	**12/1/2025**
MONTHLY PLAN DAY	**1st of the month**
PARTICIPATING PHARMACY NETWORK	**"S" Cigna**
PLAN TYPE	**Core Value**

You have the freedom to use any provider You chose, since this Plan does not utilize a Health Care Provider Network, except that:

- For the purpose of obtaining Outpatient Prescription Drug Benefits or Specialty Pharmaceuticals, this Plan requires the use of Participating Pharmacies.
- For the purpose of obtaining transplant benefits, this Plan requires the use of Designated Transplant Providers.

BENEFIT YEAR MODE	**Plan Year**

Any refernces to "annual' or "Year" mean Plan Year, except as otherwise specified in this Plan.

- Claim accumulators and cost sharing features (such as Deductibles and Out-of-Pocket Limits), reset each Plan Year, except as otherwise noted.
- Maximum Benefit limitations reset each Plan Year, except as otherwise noted.

This Benefit Summary contains limited information about Your Plan. PLEASE READ YOUR SUMMARY PLAN DESCRIPTION CAREFULLY TO UNDERSTAND YOUR COVERAGE.

The Utilization Review Provisions must be utilized to be eligible to receive the maximum benefits available under the Plan. Refer to the Utilization Review Provisions for the medical benefits that must be reviewed.

Payment of Plan benefits will be subject to all benefit provisions, Maximum Allowable Amount provisions, Utilization Review Provisions, and other terms, limits, or conditions of the Plan ("Plan parameters"). If a Health Care Practitioner, facility, Pharmacy, or supplier charges an amount above the Plan parameters, the Covered Person may be billed for the balance due. If this occurs, please call the toll free number for Customer Service and Eligibility located on the identification (ID) card for assistance.

The benefits listed in this Benefit Summary are for each Covered Person, unless otherwise indicated. Benefit levels stated herein are effective as of the Plan Effective Date shown above. This Benefit Summary replaces any prior version with an earlier date.

Vendors or service coordinators utilized for specific services listed in the Benefit Summary are subject to change.

Plan Deductible

The Plan Deductibles are listed below, unless specified elsewhere in the Benefit Summary.
All Deductibles are calculated separately. Applicable Deductibles must be satisfied prior to any payment of Covered Charges.

Single Plan Deductible each Plan Year	$3,500.00
Family Plan Deductible each Plan Year	$7,000.00

Once (2) or more Covered Persons have collectively met the maximum Family Plan Deductible, no additional Deductible will be taken during the Plan Year.

Plan Coinsurance

The Plan Coinsurance is listed below, unless specified elsewhere in the Benefit Summary.

Plan Coinsurance	
Coinsurance	70% of Covered Charges*, until the Plan Out-of-Pocket Limit is satisfied

*All Covered Charges are subject to Maximum Allowable Amount provisions and Plan parameters.

Plan Out-of-Pocket Limit

The Plan Out-Of-Pocket Limit listed below resets each Year, in accordance with the selected Benefit Year Mode.
Once the total Plan Out-of-Pocket Limit is met, the Plan pays 100% of Covered Charges, unless otherwise specified.
All Out-of-Pocket Limits are calculated separately.
Applicable Out-of-Pocket Limits must be satisfied prior to any payment of Covered Charges.
Out-of-Pocket Limits include any applicable cost-sharing – such as, Deductibles, Coinsurance, or any applicable Copayments – unless otherwise noted.
Charges for Gene Therapy services that are not obtained from a Designated Gene Therapy Provider are not covered, and do not apply toward any Out-of-Pocket Limit.
Charges for Specialty Pharmaceuticals for self-administration obtained from a Pharmacy that is not a Specialty Pharmacy Provider are not covered, and do not apply toward any Out-of-Pocket Limit.

Plan Out-of-Pocket Limit	
Single Plan	$8,550.00
Family Plan	$17,100.00

Inpatient Hospitalization Services

Subject to Plan Deductible and Plan Coinsurance.

Transplant Benefits	Designated Transplant Provider Benefits	Non-Designated Transplant Provider Benefits
Transplant Services:	Subject to Plan Deductible and Plan Coinsurance	None/Not Covered

The following transplant benefits are limited to a combined Maximum Benefit of $10,000 per transplant:

- authorized travel expenses, as described in the Medical Benefits section, when a Designated Transplant Provider is used.

Emergency And Ambulance Services

Subject to Plan Deductible and Plan Coinsurance

Use of an Emergency Room for a condition that is not an Emergency Medical Condition will result in a 30% reduction in Covered Charges. The 30% penalty You must pay for non-emergency use of an Emergency Room does not apply toward the Plan Out-of-Pocket Limit.

Professional ground, air, or water emergency medical transportation in an ambulance for a Covered Person who needs Emergency Treatment for a Sickness or an Injury to the nearest Hospital or Emergency Room that can treat the Sickness or Injury is subject to Plan Deductible and Plan Coinsurance.

Non-emergency professional transportation in an ambulance for a Covered Person is subject to Plan Deductible and Plan Coinsurance.

Outpatient Medical Services

Subject to Plan Deductible and Plan Coinsurance

Diabetic services Covered Charges include:

- Eye Examinations: Both eyes, 1 per Plan Year per Covered Person
- Foot Examination: Both feet, 1 per Plan Year per Covered Person
- Nutritional Counseling: When first diagnosed or when changes in condition occur

Benefits will be reduced for additional surgical procedures, which are not incidental, performed in the same operative session as the primary surgical procedure. Payment reduction is determined by the number of surgical procedures performed, and will be applied as follows:

- 50% reduction for the second surgical procedure, including any bilateral procedure; and
- 50% reduction for each additional surgical procedure thereafter.

Any applicable Copayments apply toward the applicable Plan Out-of-Pocket Limit.

Office Visit Copayments:	Benefits
Primary Care Practitioner Office Visits	$40.00 Copayment per Office Visit After Copayment, Primary Care Practitioner Office Visits paid at 100% of Covered Charges
Specialty Care Provider Office Visits	$60.00 Copayment per Office Visit After Copayment, Specialty Care Provider Office Visits paid at 100% of Covered Charges
Urgent Care Facility Copayments:	**Benefits**
Urgent Care Facility Visits	$75.00 Copayment per Urgent Care Facility Visit After Copayment, Urgent Care Facility Visits are paid at 100%

Clinical Preventive Services

	Benefits
Clinical Preventive Services	100% of Covered Charges; Plan Deductible and Plan Coinsurance Waived

Preventive Medicine Services

	Benefits
Preventive Medicine Services	Subject to Plan Deductible and Plan Coinsurance

Diagnostic Imaging Services And Laboratory Services

Subject to Plan Deductible and Plan Coinsurance.

Accident Medical Expense Benefit

The optional Accident Medical Expense Benefit is NOT included in this Plan.

Outpatient Physical Medicine Services

Subject to Plan Deductible and Plan Coinsurance.

Outpatient Physical Medicine Services for Physical Therapy, Occupational Therapy, Speech Therapy, pulmonary rehabilitation, adjustment and manipulations (i.e., chiropractic care), cardiac rehabilitation, and treatment of Developmental Delay, are limited to a combined Maximum Benefit of 30 visits each Plan Year, per Covered Person.

Home Health Care Services

Subject to Plan Deductible and Plan Coinsurance.

Benefits are limited to a Maximum Benefit of 60 visits each Plan Year, per Covered Person.

Hospice Services

Subject to Plan Deductible and Plan Coinsurance.

Inpatient Rehabilitation Services

Subject to Plan Deductible and Plan Coinsurance.

Benefits are limited to a Maximum Benefit of 31 days each Plan Year, per Covered Person.

Subacute Rehabilitation Facility And Skilled Nursing Facility Care

Subject to Plan Deductible and Plan Coinsurance.

Benefits are limited to a Maximum Benefit of 31 days each Plan Year, per Covered Person.

Durable Medical Equipment And Personal Medical Equipment

Subject to Plan Deductible and Plan Coinsurance.

Benefits for one (1) initial hair prosthesis, per distinct diagnosis. Covered Charges are limited to a Maximum Benefit of $250 each Plan Year, per Covered Person.

Maternity And Newborn Care Services

Subject to Plan Deductible and Plan Coinsurance.

Family Planning Services

Subject to Plan Deductible and Plan Coinsurance.

Behavioral Health And Substance Abuse Services

Subject to Plan Deductible

Subject to Behavioral Health And Substance Abuse Services Coinsurance.

The Behavioral Health And Substance Abuse Services Coinsurance applies to the applicable Plan Out-of-Pocket Limit.

	Benefits
Behavioral Health And Substance Abuse Services Coinsurance:	50% until the Plan Out-of-Pocket Limits are satisfied

Benefits for Inpatient treatment for Behavioral Health and Substance Abuse are limited to a combined 30 days each Plan Year per Covered Person.

Benefits for Outpatient treatment for Behavioral Health and Substance Abuse are limited to a combined 40 visits each Plan Year per Covered Person.

Covered Charges Incurred during an Office Visit for Behavioral Health and Substance Abuse Services are subject to the Primary Care Practitioner Office Visit Copayment as shown in the Outpatient Medical Services section. After Copayment, Primary Care Practitioner Office Visits are paid at 100%. The Primary Care Practitioner Office Visit Copayment applies to the applicable Plan Out-of-Pocket Limit.

Gene Therapy Services

Subject to Plan Deductible and Plan Coinsurance

Gene Therapy Benefits	Designated Gene Therapy Provider Benefits	Non-Designated Gene Therapy Provider Benefits
Gene Therapy Services:	Subject to Plan Deductible and Plan Coinsurance	None/Not Covered

Gene Therapy Services must be obtained through a Designated Gene Therapy Provider to be considered Covered Charges. Charges for Gene Therapy Services that are not obtained from a Designated Gene Therapy Provider are not covered, and do not apply toward any Out-of-Pocket Limit.

Gene Therapy Services will not be covered unless they have been authorized in accordance with the Utilization Review Provisions.

Recuro Health Virtual Services

	Benefits
Recuro Health Virtual Urgent Care Visit:	100% of Covered Charges per Recuro Health Virtual visit; Plan Deductible and Plan Coinsurance Waived
Recuro Health Virtual Counseling Visit:	100% of Covered Charges per Recuro Health Virtual visit; Plan Deductible and Plan Coinsurance Waived Available to a Covered Person 10 years of age and older.
Recuro Health Virtual Psychiatry Visit:	Access to Recuro Health Virtual Psychiatry Visits subject to Recuro Health Access Fees. Any applicable Access Fees are due directly to Recuro Health and will accumulate towards the Plan Deductible and Plan Out-of-Pocket. Available to a Covered Person 14 years of age and older.

For more information, you may call Recuro Health at 855-6RECURO or visit https://member.recurohealth.com

Vori Health® Services

	Benefits
Vori Health® Evaluation:	100% of Covered Charges per Vori Health Evaluation; Plan Deductible, Plan Coinsurance and Maximum Benefit waived*. *Charges on HSA eligible plans will be subject to member cost sharing pursuant to applicable federal law. If federal law is not extended to allow first dollar coverage for virtual services on HSA eligible plans, all Vori Health services may be subject to changes in cost-sharing.
Vori Health® Treatment Plans:	100% of Covered Charges per Vori Health Treatment Plan; Plan Deductible, Plan Coinsurance and Maximum Benefit waived when services are for knee, hip, shoulder, cervical spine and/or lumbar spine conditions*. Services rendered through Vori Health virtual platform to treat any condition other than the conditions listed above are subject to any applicable Copayment, Plan Deductible, Plan Coinsurance and Maximum Benefit. *Charges on HSA eligible plans will be subject to member cost sharing pursuant to applicable federal law. If federal law is not extended to allow first dollar coverage for virtual services on HSA eligible plans, all Vori Health services may be subject to changes in cost-sharing.
Availability of Vori Health® Services may vary by the Covered Person's location. Availability is subject to change. For detailed availability information, you may call Vori Health at 1 (866) 719-9611 or visit www.vorihealth.com/allstate.	

Specialty Pharmaceutical Services

Subject to Plan Deductible and Plan Coinsurance.
When a Specialty Pharmaceutical is administered, dispensed, or received on an Outpatient basis through a method other than self-administration, and is covered under the Specialty Pharmaceutical Services provision in the Medical Benefits section, any administration fees are covered under the Outpatient Medical Services provision.
For benefits for Specialty Pharmaceuticals that are obtained through a Pharmacy for self-administration, see the Outpatient Prescription Drug Benefits section.
Specialty Pharmaceuticals will not be covered unless they have been authorized in accordance with the Utilization Review Provisions.

Outpatient Prescription Drug Benefits

The Drug List includes certain Clinical Preventive Medications And Products, as identified in accordance with the Affordable Care Act. The Plan pays 100% of the Covered Charges for these Clinical Preventive Medications And Products when obtained in accordance with a valid Prescription Order. If You have questions regarding which Drug List items and preventive medications are paid at 100%, please contact the Participating Pharmacy Network listed on Your identification (ID) card.

Specialty Pharmaceuticals for self-administration obtained from a Specialty Pharmacy Provider are subject to applicable Plan Deductible and Plan Coinsurance.

Specialty Pharmaceuticals for self-administration that are obtained from a Pharmacy other than a Specialty Pharmacy Provider are not covered, and charges will not apply toward satisfying any Out-of-Pocket Limit.

Specialty Pharmaceuticals obtained from a Specialty Pharmacy Provider for self-administration will not be covered unless they have been authorized in accordance with the Utilization Review Provisions and any applicable Specialty Pharmacy Program.

For benefits for Specialty Pharmaceuticals which are administered, dispensed, or received on an Outpatient basis through a method other than self-administration, see the Specialty Pharmaceutical Services provision in the Medical Benefits section.

Prescription Drug* Copayment:
*Does not apply to Specialty Pharmaceuticals

	Participating Pharmacy	Non-Participating Pharmacy
Generic Drug:	$20.00	None/Not Covered
Preferred Brand Name Drug:	$50.00	None/Not Covered
Non-Preferred Brand Name Drug:	$75.00	None/Not Covered
	Participating Mail Service Prescription Drug Vendor	**Non-Participating Mail Service Prescription Drug Vendor**
Generic Drug:	$60.00	None/Not Covered
Preferred Brand Name Drug:	$150.00	
Non-Preferred Brand Name Drug:	$225.00	

III. COVERED EMPLOYEE EFFECTIVE DATE AND TERMINATION DATE

Eligibility And Effective Date Of Covered Employee

A person who is eligible may elect to be covered under this Plan by completing and signing an enrollment form that is approved by Us. Verification of eligibility may also be required. The date coverage begins depends upon the date on which the Plan first becomes effective for the enrollment of Employees and the date a person first enrolls for coverage.

You will be covered under this Plan on the latest of the following dates:

1. On the date the Employer's Plan first becomes effective provided that You:

    a. Are eligible for coverage on that date; and
    b. Perform duties on a Full-Time Basis for the Employer; and
    c. Have satisfied any Employment Waiting Period; and
    d. Enroll for coverage during the initial enrollment period.

2. On the date You first become eligible for coverage provided that You:

    a. Are Currently Performing Services for the Employer; and
    b. Have satisfied any Employment Waiting Period; and
    c. Enroll for coverage on or before the date You first become eligible for coverage.

3. On the first day of the calendar month following the date You enroll for coverage provided that You:

    a. Are Currently Performing Services for the Employer; and
    b. Have satisfied any Employment Waiting Period, if applicable; and
    c. Enroll for coverage within 31 days after You first become eligible for coverage.

4. On the date provided in accordance with a Special Enrollment Period.

5. On the first day following the satisfaction of a 90 day Employment Waiting Period, if applicable.

If both You and Your spouse work for the same Employer, only one person may elect coverage for any Dependents under this Plan. You and Your spouse cannot be covered under the Plan as both a Covered Employee and a Dependent.

Covered Employee's Termination Date

Your coverage and all benefits will terminate at 12:01 a.m. local time at the main office of the Employer on the first day of the Billing Period that commences immediately after the first to occur of the following events:

1. The date this Plan terminates, unless otherwise prohibited by applicable law.

2. The date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person with regard to eligibility for this coverage or filing a claim for benefits.

3. When You are no longer employed by the Employer or treated or considered an Employee by the Employer. You will be considered no longer employed by the Employer if You are laid off or retired from the Employer.

4. When You stop Currently Performing Services for the Employer, including layoff, retirement or leave of absence (other than a leave of absence You are entitled to under the federal Family and Medical Leave Act). The Monthly Plan Day is stated on the Benefit Summary.

5. When You become a temporary, seasonal, or part-time Employee of the Employer, unless the Employer has elected to cover part-time Employees or required by law.

6. When You join, on a full-time basis, the military forces of any country or the service of any governmental agency involving employment outside the United States, except to the extent coverage is required by USERRA or other applicable law.

7. A required payment owed by the Covered Employee with regard to coverage under the Plan was not paid to Employer.

IV. DEPENDENT EFFECTIVE DATE AND TERMINATION DATE

Eligibility Of Dependent
If Dependents are eligible for coverage under the Plan, then Your Dependent is eligible for coverage under this Plan on the latest of the following dates:

1. The date coverage for Dependents is available under the Plan.

2. The date You become eligible for coverage under this Plan.

3. The date on which a person meets the definition of a Dependent.

4. The date provided in accordance with a Special Enrollment Period.

Verification of eligibility may also be required.

Effective Date Of Dependent
A Dependent cannot be covered under this Plan until You are covered under this Plan, unless otherwise authorized by the Employer. To obtain coverage for Your Dependents, You must apply for Dependent coverage under this Plan by filling out an enrollment form. You must submit any health or other information required by the enrollment form. If approved, coverage for Your Dependents will take effect at 12:01 a.m. local time at the main office of the Employer on the next billing due date that coincides with:

1. The Eligibility Date, if You apply for Dependent coverage on or before Your Effective Date and the Dependent is included on Your initial enrollment form for coverage under this Plan; or

2. The Enrollment Date, if You apply for Dependent coverage within 61 days after the Dependent first becomes eligible for coverage under Your Plan.

You must provide written notification and an enrollment form for any change in Dependent status within 61 days of the change.

Adding A Newborn Child
Coverage for a newborn Dependent child will take effect at the moment of birth, if notification is provided for Dependent coverage and You pay any required monthly contribution within 61 days after the newborn child's birth. The retroactive coverage is subject to Your timely submission of the notification and any required monthly contribution.

If notification and the required monthly contribution are not received within the first 61 days from the newborn child's birth, the newborn child will not be covered from the date of birth, and all coverage for Your newborn child is forfeited as of the moment of birth.

If notification and the required contribution are not received within the 61 day time frame, and You later want to obtain coverage for your Dependent child, You must wait until the next date provided for in accordance with a Special Enrollment Period, or until the next Annual Open Enrollment Period, to apply for coverage under this Plan for Your eligible Dependent child.

Adding An Adopted Child Or Child Placed For Adoption
Coverage for a newly adopted Dependent child, or such child placed for adoption, will take effect on the date the child becomes a Dependent, if notification is provided for Dependent coverage and You pay any required monthly contribution within 61 days after the child's adoption or placement for adoption. The

retroactive coverage is subject to Your timely submission of the notification and any required monthly contribution.

If notification and the required contribution are not received within the first 61 days from the child's adoption or placement, the child will not be covered from adoption or placement, and all coverage for Your newly adopted child is forfeited as of the date of the child's adoption or placement for adoption.

If notification and the required contribution are not received within the 61 day time frame, and You later want to obtain coverage for your Dependent child, You must wait until the next date provided for in accordance with a Special Enrollment Period, or until the next Annual Open Enrollment Period, to apply for coverage under this Plan for Your eligible Dependent child.

Adding A Child For Whom A Court Order Requires You To Provide Health Coverage
A child for whom a court order requires You to provide health coverage will be covered if We receive a qualified medical child support order and any required contribution within 61 days of the court order. Coverage will take effect on the date of the court order, if notification is provided for Dependent coverage and any required monthly contribution is received within 61 days of the court order. The retroactive coverage is subject to Your timely submission of the notification and any required monthly contribution.

If notification and the required contribution are not received within the first 61 days from the date of the court order, the child will not be covered from the date of the court order, and all coverage for Your child is forfeited as of the date of the court order.

If notification and the required contribution are not received within the 61 day time frame, and You later want to obtain coverage for your Dependent child, You must wait until the next date provided for in accordance with a Special Enrollment Period, or until the next Annual Open Enrollment Period, to apply for coverage under this Plan for Your eligible Dependent child.

The Plan will provide benefits in accordance with any qualified medical child support order (QMCSO), as defined in ERISA Section 609(a). Under no circumstance is the Plan required to provide benefits pursuant to a QMCSO that are not otherwise provided by the Plan.

Termination Date Of Covered Dependent
Coverage and all benefits for a Covered Dependent will terminate at 12:01 a.m. local time at the main office of the Employer on the first day of the Billing Period that commences immediately after the first to occur of the following events:

1. We receive Your written request, or a later date that is requested, for termination of a Covered Dependent; or

2. When this Plan terminates; or

3. When the Employer's Plan is changed to no longer allow Dependent coverage for the Dependent; or

4. When a Covered Dependent no longer meets the Dependent definition in this Plan; or

5. For Your spouse's coverage only, when You and Your spouse are legally divorced; or

6. When a Covered Dependent joins, on a full-time basis, the military forces of any country or the service of any governmental agency involving employment outside the United States, except to the extent coverage is required by USERRA or other applicable law; or

7. A required payment due by the Covered Dependent for coverage under the Plan was not paid to Employer.

V. UTILIZATION REVIEW PROVISIONS

Utilization Review Process
The Covered Person must call the toll free number for medical services that require prior authorization, located on the identification (ID) card, to obtain authorization for the services listed under the When To Call provision in this section. Benefits will be reduced or excluded as described in the Reduction of Payment provision in this section, if a Covered Person does not comply with this Utilization Review Process and does not obtain authorization.

A review by the Medical Review Manager does not guarantee that benefits will be paid under this Plan. The Medical Review Manager only determines whether or not medical care is Medically Necessary.

Payment of benefits will be subject to all the terms, limits and conditions in this Plan ("Plan parameters").

The review process must be repeated if treatment is received more than 30 days after review by the Medical Review Manager or if the type of treatment, admitting Health Care Practitioner or facility differs from what the Medical Review Manager authorized.

A determination by the Medical Review Manager does not alter, limit or restrict in any manner the attending Health Care Practitioner's ultimate patient care responsibility.

Utilization Review Procedures
To obtain authorization, the Covered Person must contact the Medical Review Manager by calling the toll free number for medical services that require prior authorization located on the ID card. Please have all of the following information on hand before calling:

1. The group number for this Plan.

2. The Health Care Practitioner's name and telephone number.

3. The service, procedure and diagnosis.

4. The proposed date of admission or date the service or procedure will be performed.

5. The facility's name and phone number.

The Medical Review Manager may review a proposed service or procedure to determine: Medical Necessity; whether it is a Cosmetic Service or an Experimental or Investigational Service; location of the treatment; and length of stay for an Inpatient confinement. As part of the review process, the Medical Review Manager may require, at the Plan's expense, a second opinion from a Health Care Practitioner recommended by the Medical Review Manager.

When To Call
Contact the Medical Review Manager for authorization of the following services.

1. **Inpatient Confinements:** Call Us to obtain authorization for an admission to, or transfer between, an Acute Behavioral Health Inpatient Facility, a Hospital, an Acute Medical Rehabilitation Facility, a Behavioral Health Rehabilitation and Residential Facility, a Subacute Rehabilitation Facility, a

Hospice facility, a Nursing Facility, or any other Inpatient confinement that will exceed 24 hours as follows:

a. Non-Emergency Confinements: Call at least 7 business days prior to an Inpatient admission for a non-emergency confinement that will exceed 24 hours in length.
b. Emergency Confinements: Call within 24 hours, or as soon as reasonably possible, after admission for an Emergency Confinement that will exceed 24 hours in length. The Covered Person must provide, or make available, to the Medical Review Manager the full details of the Emergency Confinement. Covered Emergency Treatment received at an Emergency Room will be provided without the requirement for prior authorization, regardless of whether the provider is a Participating Provider or not.
c. Maternity Confinements: If the Inpatient confinement exceeds 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated caesarean section delivery, the Covered Person must call prior to the end of the confinement, or as soon as reasonably possible. Any other Inpatient confinements that occur during a pregnancy must be authorized in accordance with the Non-Emergency Confinements and Emergency Confinements provisions above.

2. **Outpatient Procedures:** Call Us to obtain authorization for the following non-emergency procedures that are performed as an Outpatient in a Hospital, an Acute Medical Rehabilitation Facility, a Free-Standing Facility, a Subacute Rehabilitation Facility, an Urgent Care Facility, or in a Health Care Practitioner's office. Call at least 7 business days prior to receiving any non-emergency Outpatient services that are listed below. Call within 24 hours, or as soon as reasonably possible, after receiving Emergency Treatment involving any of the Outpatient services listed below.

a. Any surgical procedures, except those rendered in a Health Care Practitioner's office.
b. Invasive cardiology services for diagnostic or therapeutic cardiac procedures, except cardiac catheterization and percutaneous transluminal coronary angioplasty (PTCA).
c. Dialysis.
d. Hyperbaric Oxygen Therapy (HBOT).
e. Chemotherapy.
f. Radiation therapy, including, but not limited to:
    i. Brachytherapy (internal radiation therapy);
    ii. Conventional external beam radiation therapy (CRT);
    iii. Image guided radiotherapy (IGRT);
    iv. Intensity-modulated radiotherapy (IMRT);
    v. Ionizing radiation;
    vi. Proton therapy (proton beam therapy) (PBT);
    vii. Stereotactic radiosurgery (SRS); or,
    viii. Three-dimensional conformal radiation therapy (3DCRT).

3. **Diagnostic Imaging Services and Laboratory Services:** Call at least 7 business days prior to receiving any of the following non-emergency services:

a. Capsule Endoscopy;
b. Computed Tomography (CT);
c. Magnetic Resonance Angiogram (MRA);
d. Magnetic Resonance Imaging (MRI);
e. Positron Emission Tomography (PET) Scan;
f. Scintimammography; or,
g. Peripheral Bone Density Test – Heel Only.

4. **Transplants:** Call at least 7 business days prior to any transplant evaluation, testing, preparative treatment, or donor search.

5. **Gene Therapy:** Call at least 7 business days prior to any Gene Therapy evaluation, testing, preparative treatment, or services.

6. **Non-Emergency Professional Transportation:** Call at least 7 business days, or as soon as reasonably possible, prior to any non-emergency professional air or water ambulance transportation, by any means, for a Covered Person who is under the care or supervision of a Health Care Practitioner when the transport is any of the following:

    a. To a Hospital that provides care, services, or treatment that was not available at the original Hospital.
    b. To a more cost-effective Inpatient facility that can provide care, services, or treatment for the Covered Person's Sickness or Injury.
    c. From a facility that provides acute care, to a facility that provides Subacute Medical Care, on an Inpatient basis.
    d. From a facility that provides acute care or Subacute Medical Care on an Inpatient basis, to the Covered Person's home, when professional transportation in an ambulance is determined to be Medically Necessary.

7. **Pharmaceuticals:** Call at least 7 business days prior to obtaining any drug regimen for which the Drug List requires authorization, including but not limited to beginning a course of non-intravenous injectable drug therapy, or intravenous injectable parenteral drug therapy, such as chemotherapy. The Drug List identifies which Prescription Drugs require prior authorization. For a Covered Person's first-time use of any Specialty Pharmaceutical, we may limit Our authorization to an initial 15-day treatment regimen. If the treatment regimen is continued, additional supply may be authorized.

8. **Durable Medical Equipment and Personal Medical Equipment:** Call at least 7 business days prior to the purchase or rental of Durable Medical Equipment and Personal Medical Equipment with a purchase price in excess of $1,500.

9. **Home Health Care and Hospice Care:** Call at least 7 business days prior to beginning Home Health Care, including home infusion, or Hospice Care.

10. **Other Services:** Call at least 7 business days prior to receiving Inpatient or Outpatient services for the following:

    a. Implants, prosthesis and/or replacement of any joint, including but not limited to spine, knee and hip.

11. **Outpatient Behavioral Health and Substance Abuse Services:** Call at least 7 business days prior to receiving Outpatient services for Behavioral Health or Substance Abuse, including, but not limited to:

    a. Residential treatment center (RTC) admission;
    b. Partial hospitalization programs (PHPs);
    c. Intensive outpatient programs (IOPs);
    d. Psychological testing;
    e. Neuropsychological testing;
    f. Psychiatric home care services; or
    g. Detoxification.

Continued Stay Review
The Medical Review Manager may request additional clinical information during an Inpatient confinement. Failure of the Health Care Practitioner or facility to provide the requested information will result in non-authorization of continued Inpatient confinement. No benefits will be considered until the additional information is received by the Medical Review Manager.

No benefits will be paid for the days of Inpatient confinement beyond the originally scheduled discharge date if the continued stay would not have been authorized by the Medical Review Manager based on review of the additional information provided.

Reduction Of Payment
The effect of noncompliance with the utilization review process is:

1. No benefits will be paid under this Plan for any transplant services that are not authorized by the Medical Review Manager prior to transplant evaluation, testing, preparative treatment or donor search.

2. No benefits will be paid under this Plan for any Gene Therapy services that are not authorized by the Medical Review Manager before services are rendered.

3. No benefits will be paid under this Plan for any non-emergency professional air or water transportation services that are not authorized by the Medical Review Manager prior to transport.

4. Benefits will not be paid for any Specialty Pharmaceuticals that are not authorized by the Medical Review Manager.

5. If authorization is not obtained for the Covered Person's course of treatment for other services as provided in the When to Call provision above, benefits will be reduced for otherwise Covered Charges by 30%, but by no more than $1,000 per course of treatment. Examples of failure to obtain authorization include:

    a. The Covered Person fails to obtain authorization for the treatment from the Medical Review Manager.
    b. The Covered Person does not contact the Medical Review Manager within the required timeframe.
    c. The type of treatment, admitting Health Care Practitioner or facility differs from what was authorized by the Medical Review Manager.
    d. The treatment is Incurred more than 30 days after review by the Medical Review Manager.

    The reduced amount, or any portion thereof, under this section will not count toward satisfying any Coinsurance, Copayment, Deductible, or Out-of-Pocket Limit.

Utilization Review Decisions
The Medical Review Manager, upon notification, will determine (in consultation with the Covered Person's Health Care Practitioner) whether or not an Inpatient confinement, surgery, or other medical care is Medically Necessary. The Medical Review Manager will certify all such medical care that is determined to be Medically Necessary or suggest other care options that may exist for treatment of the condition.

For Inpatient admissions, the Medical Review Manager will also certify the number of days of confinement that are considered to be Medically Necessary. If the attending Health Care Practitioner feels, due to extenuating circumstances, that additional days are required to treat the condition properly,

he or she may contact the Medical Review Manager to discuss the Medical Necessity of an extended length of stay and request certification for additional days.

Any medical care or confinement that is not determined to be Medically Necessary will not be certified and will not be eligible for benefits.

The Medical Review Manager will notify the Covered Person promptly of its determination. It will also notify the Medical Facility or Behavior Health Facility and the Covered Person's Health Care Practitioner.

If the Covered Person or his/her Health Care Practitioner does not agree with the decision of the Medical Review Manager, the decision may be appealed according to the appeal provisions listed in the Claim Provisions section.

The Medical Review Manager only determines whether or not medical care is Medically Necessary. A utilization review decision certifying Medical Necessity does not guarantee that benefits will be paid under this Plan. The Plan will pay Covered Charges only for the services and supplies listed in the SPD. Refer to the Exclusions section of the SPD for services and supplies that are not covered under this Plan.

If the Covered Person uses Vori Health's virtual platform for covered Vori Health Evaluations or covered Vori Health Treatment Plans, the Utilization Review Provisions are deemed as met.

VI. PROVIDER CHARGES AND MAXIMUM ALLOWABLE AMOUNT PROVISIONS

Services and supplies for which the Plan has a Negotiated Rate or Contracted Rate are not subject to Maximum Allowable Amount reductions. The Covered Person's cost-sharing under the Plan is based on the Negotiated Rate or Contracted Rate for the covered goods or services provided.

Maximum Allowable Amounts
Providers that have not established a Negotiated Rate or Contracted Rate with the Plan, or Network Manager, may charge more than the Plan determines to be a Maximum Allowable Amount for covered services and supplies. Any Covered Charges approved subject to the Plan's terms, limits, and conditions ("Plan parameters") will be limited to what the Plan determines to be the Maximum Allowable Amount.

A Covered Person is responsible for any portion of the billed amount not covered or paid by the Plan, in addition to any other applicable fees including, but not limited to, any Coinsurance, Copayment, and Deductible.

Methodologies
For goods and services, other than Specialty Pharmaceuticals, provided by a Health Care Practitioner, facility or supplier who has not established a Negotiated Rate or Contracted Rate with the Plan, the Maximum Allowable Amount is the lesser of billed charges or the amount determined and established by the Plan, at the Plan Administrator's discretion, using normative data and submitted information in accordance with one or more of the following methodologies:

1. For Inpatient fees and services, 150% of the amount as would be allowed to the facility or provider of a similar type and/or in the same geographic area by The Centers for Medicare and Medicaid Services (CMS) if Medicare was the payer, regardless if the provider has agreed to Medicare rates or not, for the same or similar goods and services reported on the claim, established utilizing the most currently available Medicare reimbursement schedules and methodologies, except that the Plan may apply the following alternatives:

    a. 130% of the amount allowed by CMS for the same or similar x-ray, imaging and/or laboratory services.
    b. 130% of the amount allowed by CMS for the same or similar Durable Medical Equipment and Personal Medical Equipment (including rental).
    c. 100% of the amount allowed by CMS for the same or similar dialysis services.
    d. For implants, prostheses and joint replacements, the amount paid by the provider or facility to the supplier of the goods based on the invoice price less any rebates or discounts, but not to exceed 130% of the amount allowed by CMS for the same or similar goods.

2. For Outpatient fees and services, 130% of the amount as would be allowed to the Health Care Practitioner, supplier, or provider of a similar type and/or in the same geographic area by The Centers for Medicare and Medicaid Services (CMS) if Medicare was the payer, regardless if the provider has agreed to Medicare rates or not, for the same or similar goods and services reported on the claim, established utilizing the most currently available Medicare reimbursement schedules and methodologies, except that the Plan may apply the following alternative: 100% of the amount allowed by CMS for the same or similar dialysis services.

3. For Facility claims, Amount Generally Billed for Participants who are eligible for financial assistance.

4. For injectable therapy and services, other than Specialty Pharmaceuticals: the most common Contracted Rate paid to a contracted provider, or to a nationally contracted Designated Specialty

Pharmacy Provider, not to exceed Average Wholesale Price (AWP), or Average Sales Price (ASP); other nationally recognized drug cost basis used by nationally contracted vendors; or, any other methodology described under this plan.

5. For Prescription Drugs, other than Specialty Pharmaceuticals, the most common Contracted Rate paid to a Participating Pharmacy or to a nationally contracted Designated Specialty Pharmacy Provider, not to exceed the Average Wholesale Price (AWP), or Average Sales Price (ASP), other nationally recognized drug cost basis used by nationally contracted vendors, or, any other methodology described under this plan.

Alternative Methodologies

For goods and services, other than Specialty Pharmaceuticals, provided by a Health Care Practitioner, facility or supplier who has not established a Negotiated Rate or Contracted Rate with the Plan, and for which the above methodologies are incompatible or , the Maximum Allowable Amount is the lesser of billed charges or the amount determined and established by the Plan, at the Plan Administrator's discretion, using normative data and submitted information in accordance with one or more of the following methodologies:

1. The expected or estimated charges of facilities of a similar type and/or in the same geographic area, when providing the same or similar goods and services reported on the claim, defined as the same service as reported through Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes, Current Dental Terminology (CDT) codes, or grouping of services as determined through standard Diagnostic Related Groups (DRG), refined DRG, Ambulatory Payment Classification (APC) or other standard industry methodologies, depending upon the services and setting reported on the claim.

2. The amount a Health Care Practitioner, facility or supplier of a similar type and/or in the same geographic area bills for the same or similar goods and services as reported on the claim, based on a combined profile of derived and actual submitted charge data and relative values.

3. The amount derived by applying comparable markups from facilities of a similar type and/or in the same geographic area, to the estimated costs of the facility providing the goods and services reported on the claim, established utilizing the facility's most recently available cost reports submitted to The Centers for Medicare and Medicaid Services (CMS).

4. The average Contracted Rate and/or non-Medicare or non-Medicaid Negotiated Rate amount a Health Care Practitioner, facility or supplier of a similar type or in the same geographic area has accepted for the same or similar goods and services as reported on the claim, based on a combined profile of derived and actual submitted claims data.

5. The lowest amount a Health Care Practitioner, facility or supplier of a similar type and/or in the same geographic area, for the goods and services reported on the claim, has accepted for the same or similar goods and services, derived from Our or another payers' Maximum Allowable Fees or actual amounts paid.

Maximum Allowable Amounts For Providers Who Have Established a Negotiated Rate

For certain goods and services provided by a Health Care Practitioner, facility, or supplier who has established a Negotiated Rate, the Maximum Allowable Amount is always the Negotiated Rate, except that if a Covered Person is covered by Medicare, the Maximum Allowable Amount is the amount Medicare would pay for the goods or services. A Covered Person is not responsible for payment of

amounts billed by a provider in excess of the Maximum Allowable Amount for Covered Charges subject to the Negotiated Rate.

Maximum Allowable Amounts For Certain Participating Providers

For certain goods and services provided by a Participating Provider, the Maximum Allowable Amount is the lesser of billed charges or the Contracted Rate, except that if a Covered Person is covered by Medicare, the Maximum Allowable Amount is the amount Medicare would pay for the goods or services. A Covered Person is not responsible for payment of amounts billed by a Participating Provider in excess of the Maximum Allowable Amount for Covered Charges received within the Covered Person's Health Care Provider Network.

Maximum Allowable Amount Determinations

Additional Amounts

The Plan Administrator may, in its discretion, deem a greater amount 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:

1. Unusual circumstances;

2. Complications requiring an additional (or a lesser) amount of time, skill, or experience in connection with a particular service or supply;

3. Industry standards and practices, as they relate to similar scenarios; or

4. The cause of the Sickness or Injury necessitating the service(s) or treatment(s).

Provider Error

The determination that fees for services are includable in the Maximum Allowable Amount will be made by the Plan Administrator, taking into consideration (but not limited to), the findings and assessments of the following entities:

1. The national medical associations, societies, and organizations; and

2. The Food and Drug Administration (FDA).

In all instances, the Maximum Allowable Amount 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 Health Care Practitioner, including errors in medical care that are clearly identifiable, preventable, and services in their consequence for patients. A finding of provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

Billing Practices

To be includable in the Maximum Allowable Amount, 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 Plan. The Maximum Allowable Amount will not include any identifiable billing mistakes, such as: up-coding; duplicate charges; and, charges for services not performed.

Methodology Is Subject To Change

The Maximum Allowable Amount methodologies listed above may be amended or replaced from time to time at the Plan's discretion, without notice.

Using The Health Care Provider Network

To receive payment for transplant benefits, Outpatient Prescription Drug benefits, and benefits for Specialty Pharmaceuticals, You and Your Covered Dependents must meet the requirements for using providers participating in the Health Care Provider Network, and must comply with all other Plan requirements. IT IS YOUR RESPONSIBILITY to verify that a provider/pharmacy is participating in the Health Care Provider Network, and whether that provider is participating as a Participating Provider or Participating Pharmacy at the time of service.

Receiving Care For Emergency Conditions
Covered Charges for Emergency Treatment received in an Emergency Room, and Emergency Confinement, will be paid until the Covered Person's condition has Stabilized. If requested by the Covered Person, assistance in the Covered Person's transfer to a different Hospital or facility will be provided, if possible.

Covered Charges for any approved Emergency Treatment or Emergency Confinement may be subject to reductions pursuant to the Maximum Allowable Amounts provisions and other Plan parameters. A Covered Person is responsible for any portion of the billed amount not covered by the Plan, in addition to any other applicable fees including, but not limited to, any Coinsurance, Copayment, and Deductible.

Receiving Ancillary Services
Certain ancillary services—such as lab tests, or services performed by anesthesiologists, radiologists, pathologists, or Emergency Room physicians—are sometimes provided in association with direct treatment from a provider. Covered Charges are subject to the Maximum Allowable Amounts provisions and other Plan parameters.

VII. MEDICAL BENEFITS

The Plan will pay Covered Charges only for the services and supplies listed as Medical Benefits in this section of the SPD for You and Your Covered Dependents (if applicable).

How Covered Charges are paid and the Maximum Benefit for the covered services and supplies listed in this section are shown in the Benefit Summary. Refer to the Exclusions section of the SPD for services and supplies that are not covered under this Plan.

The Covered Person must follow the Utilization Review Provisions section and the Provider Charges And Maximum Allowable Amount Provisions section to receive the maximum benefits available under this Plan.

The Plan DOES NOT require the designation of a Primary Care Practitioner.

After the Covered Person has paid any applicable Coinsurance, Copayment, Deductible, or any other applicable fees, benefits will be paid by the Plan for Covered Charges for medical benefits listed in this section of the SPD for each Covered Person. Separate Coinsurance, Copayments, Deductibles, or other fees may apply to specific types of services. Please review the Benefit Summary for additional information on any other Coinsurance, Copayment, Deductible, or other fees, and the Covered Charges to which they apply.

Benefits paid under this section are subject to any Maximum Benefit provided under this Plan. Benefits are subject to all the terms, limits and conditions in this Plan.

Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section unless they are specifically listed as Covered Charges in the Medical Benefits section.

The Plan pays only for the following Covered Charges:

Inpatient Hospitalization Services
Covered Charges Incurred for:

1. The following services that are provided in a Hospital:

    a. Daily room and board in the most appropriate setting in the Hospital.
    b. Daily room and board in an intensive care setting, such as an intensive care unit (ICU), a neonatal intensive care unit (NICU), a coronary intensive care unit (CICU) and a step-down unit.
    c. Routine nursing services.
    d. Other Medically Necessary services.

    For purposes of this provision, Covered Charges for daily room and board will be considered at a semi-private room rate. Covered Charges for daily room and board in a single or private room will be considered eligible only if a single or private room is Medically Necessary. If a Hospital has only single or private rooms, Covered Charges will be considered at the least expensive rate for a single or private room.

    For Rehabilitation Services benefits, see the Inpatient Rehabilitation Services provision even when these services are received in a Hospital. For interpretation of Diagnostic Imaging and laboratory tests benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section.

For benefits for all other professional services, see the Health Care Practitioner Services provision in this section.

2. Benefits for the following authorized transplants when a Designated Transplant Provider is used:

   a. Kidney.
   b. Cornea.
   c. Skin.
   d. Lung(s).
   e. Heart.
   f. Liver.
   g. Simultaneous kidney/pancreas.
   h. Allogeneic and autologous bone marrow transplant/stem cell rescue.
   i. Chimeric antigen receptor T-cell therapy (CAR T-Cell Therapy) used for FDA approved indications.
   j. Any other transplants that are shown in the Benefit Summary.

   You must obtain authorized transplants through a Designated Transplant Provider to receive the transplant benefits available under this Plan. Transplants obtained from a provider that is not a Designated Transplant Provider are not covered.

   All transplants must be authorized in advance by the Plan, in accordance with the Utilization Review Provisions section in this Plan.

   The transplant benefit applies to all Covered Charges for transplants, combined transplants, and sequential transplants, including replacement or subsequent transplants of the same organ. All Covered Charges associated with transplants are covered under:

      a. All Inpatient and Outpatient care, facility fees, professional fees, and follow-up care.

      b. Prescription Drug benefits, even though they may be paid under the Outpatient Prescription Drug Benefits section.

      c. Expenses Incurred for organ search and donor expenses. Organ search means administrative costs for registry, computer search for donor matches, preliminary donor typing, donor counseling, donor identification and donor activation. Benefits for donor expenses are available only when the expenses are related to a donation made to a Covered Person.

      d. Expenses Incurred for travel expenses. Authorized travel expenses to obtain the transplant surgery are paid, subject to the Plan's guidelines, for: the Covered Person and one travel companion; and, the donor and one travel companion. For CAR T-Cell Therapy, authorized travel expenses to obtain the CAR T-Cell Therapy are only available when there is no Designated Transplant Provider or Participating Provider available within 100 miles of a Covered Person's place of residence.

Covered Charges for transplants authorized by the Plan include all related medical services Incurred 14 days before the transplant surgery until 365 days after the transplant surgery, or a lesser period not to exceed the termination date of this Plan. All payments for these services are applied toward the transplant benefit.

<u>Transplants with Designated Transplant Provider:</u>

We have contracted with Designated Transplant Providers to provide transplantation services for specified types of transplants to Covered Persons at a Negotiated Rate.

No benefits will be paid under this Plan for any transplant services that are not authorized by the Medical Review Manager prior to transplant evaluation, testing, preparative treatment, or donor search. If authorized by the Medical Review Manager, the Covered Person will be referred to a Designated Transplant Provider.

If the Covered Person does not use a Designated Transplant Provider at the time the first service is Incurred for transplant services, no transplant benefits will be paid. If the Covered Person then chooses to use a Designated Transplant Provider at a later date, transplant benefits will not be paid unless the utilization review process is repeated and the transplant services are authorized by the Medical Review Manager again.

Emergency And Ambulance Services
Covered Charges Incurred for:

1. Emergency Treatment for Sickness or Injury that is performed in a Hospital or Emergency Room.

   Other applicable Plan provisions still apply to Emergency Services, including but not limited to those relating to cost-sharing, exclusions, coordination of benefits, Maximum Allowable Amount limitations, and affiliation or waiting periods.

2. Professional ground, air, or water emergency medical transportation for a Covered Person who needs Emergency Treatment for a Sickness or an Injury to the nearest Hospital or Emergency Room that can treat the Sickness or Injury. The ambulance service must meet all applicable state licensing requirements.

3. Medically Necessary non-emergency professional transportation in an ambulance for a Covered Person, when the transport is any of the following:

   a. To a Hospital that provides care, services, or treatment that was not available at the original Hospital.

   b. To a more cost-effective Inpatient facility that can provide care, services, or treatment for the Covered Person's Sickness or Injury.

   c. From a facility that provides acute care, to a facility that provides Subacute Medical Care, on an Inpatient basis.

   d. From a facility that provides acute care or Subacute Medical Care on an Inpatient basis, to the Covered Person's home.

   The ambulance service must meet all applicable state licensing requirements.

   Services for non-emergency professional transportation in an ambulance that are provided for convenience are not covered.

   Charges for non-emergency professional air or water transportation in an ambulance are covered only when terrain, distance, or patient condition warrants. Prior authorization for the non-emergency professional air or water transportation is required under the Utilization Review Provisions section.

Outpatient Medical Services
Covered Charges Incurred for:

1. Office Visit charges Incurred during an Office Visit for a Covered Person are payable as shown in the Benefit Summary. For the purpose of this provision, Office Visits include evaluation and management services, as defined in the most recent edition of Current Procedural Terminology, and preventive medicine services. An Office Visit will also include allergy shots and immunotherapy injections of inhaled allergens.

   Covered Charges under the Office Visit benefit will not include laboratory and radiology services, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), surgical procedures, chemotherapy, allergy testing, a separately billed facility fee, or any other service not specifically listed as a Covered Charge for an Office Visit.

   An Office Visit may be provided in an Urgent Care Facility; however, charges for services rendered in addition to the Office Visit charge are not considered part of the Office Visit benefit. Services provided in an Urgent Care Facility, other than the Office Visit itself, are considered below.

2. Non-emergency services performed in a Hospital's Outpatient department, a Free-Standing Facility, or an Urgent Care Facility. However, Physical Medicine is covered under the Outpatient Physical Medicine Services provision in this section.

3. Health Care Practitioner services including, but not limited to, services of a primary surgeon, an Assistant Surgeon, or a Surgical Assistant, during the surgery.

   Benefits will be reduced for additional surgical procedures performed in the same operative session. Covered Charges for services rendered by an Assistant Surgeon are limited to 16% of the Covered Charges initially allowed for the surgeon performing the surgical procedure. Covered Charges for services rendered by a Surgical Assistant are limited to 16% of the Covered Charges initially allowed for the surgeon performing the surgical procedure.

   For interpretation of Diagnostic Imaging and laboratory tests benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section.

4. Dental services related to the dental extraction of teeth, as a prerequisite of scheduled radiation therapy or covered surgery, in accordance with a dental treatment plan approved by the Plan.

5. Treatment of a Dental Injury from an Accidental blow to the face causing trauma to teeth, the gums, or supporting structures of the teeth. Treatment of Dental Injury must begin within 90 days and be completed within 365 days of the Dental Injury.

   The Covered Person may submit a Dental Treatment Plan to the Plan before treatment starts for an estimate of any benefits that would be payable. The Plan reserves the right to limit benefits to the least expensive procedure that will produce a professionally adequate result.

6. The administration of general anesthesia and related anesthesia services in a Hospital or Free-Standing Facility when dental treatment is provided to a Covered Person who:

   a. Is a child 5 years of age or under, and has a dental condition or a developmental disability for which patient management in the dental office has proved to be ineffective; or

b. Has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery.

The dental services are not covered, except as otherwise provided in the Clinical Preventive Services provision in this section.

Prior authorization for the dental care is required under either the Inpatient Confinements or Outpatient Procedures provision in the Utilization Review Provisions section.

The Covered Person may submit a Dental Treatment Plan to the Plan before treatment starts for an estimate of any benefits that would be payable.

7. Routine Patient Costs Incurred by a Clinical Trial Qualified Individual while participating in an Approved Clinical Trial.

8. Surgical treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction for only those services that are included in a treatment plan authorized by the Plan prior to the surgery.

   The following services for non-surgical treatment of TMJ and CMJ:

   a. Diagnostic examination.
   b. Injection of muscle relaxants.
   c. Therapeutic drug injections.
   d. Diathermy therapy.
   e. Ultrasound therapy.

   For Physical Therapy benefits, see the Outpatient Physical Medicine Services provision in this section.

   For Diagnostic Imaging services, see the Diagnostic Imaging Services and Laboratory Services provision in this section.

9. The following services for a Covered Person with diabetes:

   a. Routine eye exams.
   b. Nutritional counseling.
   c. Diabetic training.
   d. Routine foot care.
   e. Home glucose monitoring and diabetic supplies.

   For insulin, syringes, needles, lancets and testing agents benefits, see the Outpatient Prescription Drug Benefits section.

10. Growth hormone therapy treatment, diagnosis, or supplies (including drugs and hormones) only when such treatment is clinically proven to be effective for any of the following conditions:

    a. Growth hormone deficiency as confirmed by documented laboratory evidence.
    b. Growth retardation secondary to chronic renal failure before or during dialysis.
    c. AIDS wasting syndrome.

Growth hormone treatment must be likely to result in a significant improvement in the Covered Person's condition.

11. Reconstructive surgery:

    a. To restore function for conditions resulting from an Injury.
    b. That is incidental to, or follows, a covered surgery resulting from a Sickness or an Injury of the involved part.
    c. Following a Medically Necessary mastectomy. Reconstructive surgery includes all stages and revisions of reconstruction of the breast on which the mastectomy has been performed, reconstruction of the other breast to establish symmetry, and physical complications in all stages of mastectomy (including lymphedemas), in a manner determined in consultation with the attending provider and the patient.
    d. Because of a congenital Sickness or anomaly of a covered child that resulted in a functional defect.

    Cosmetic Services and services for complications from Cosmetic Services are not covered regardless of whether the initial surgery occurred while the Covered Person was covered under this Plan or under any previous coverage.

12. Intravenous injectable parenteral drug therapy services for total parenteral nutrition, and other fluids, blood and blood products, and medications requiring a written prescription that would be administered intravenously.

13. Non-Intravenous injectable parenteral drug therapy services for Prescription Drugs that can be administered by means of intramuscular or subcutaneous injection.

    If the injectable drug is covered under the Medical Benefits section, any administration fees are covered under this Outpatient Medical Services provision when the injectable drug is received on an Outpatient basis through a method other than self-administration. For insulin injection benefits, see the Outpatient Prescription Drug Benefits section.

14. Chronic disease management.

Clinical Preventive Services
Services for the following categories of preventive treatment required under the Affordable Care Act (ACA) (detailed information is available at www.healthcare.gov):

1. Evidence-Based Screenings and Counseling: Evidence-based items or services for preventive care that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

   For more information about the evidence-based items or services that are covered under this plan, refer to the USPSTF's current recommendations posted at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.

2. Routine Immunizations: Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention, in accordance with the appropriate immunization schedule with respect to the Covered Person involved.

For more information about the routine immunizations covered under this plan, refer to the CDC's schedule of immunizations posted at: http://www.cdc.gov/vaccines/schedules/index.html.

3. Preventive Pediatric Health Care Services: For infants, children, and adolescents, evidence-informed preventive screenings and assessments provided for in the comprehensive guidelines published by the American Academy of Pediatrics (AAP) and supported by the Health Resources and Services Administration (HRSA), in accordance with the recommended periodicity schedule of screenings and assessments applicable to the Covered Person involved.

   The preventive services to be covered for infants, children, and adolescents include immunization and screening services to the extent they are not covered within the previous two categories.

   This does not include routine well newborn care at birth. For more information about routine well newborn care covered under this Plan, refer to the Maternity Care Services provision in this section.

   For more information about the preventive pediatric health care services covered under this Plan, refer to the AAP's periodicity schedule of screenings and assessments posted at: https://www.aap.org/periodicityschedule.

4. Preventive Health Care Services For Women: For women, evidence-informed preventive care and screening provided for in the women's comprehensive preventive services guidelines supported by the HRSA, to the extent not already included in other recommendations of the USPSTF and/or HRSA.

   For more information about the preventive health care services for women covered under this Plan, refer to the HRSA's Women's Preventive Services' Guidelines posted at: http://www.hrsa.gov/womensguidelines/.

   When changes are made to the recommendations and/or guidelines for covered clinical preventive categories listed above, benefits for the new or changed clinical preventive services will be provided for Plan Years that begin on or after the date that is one (1) year after the date the recommendation or guideline is issued.

Preventive Medicine Services
Certain preventive medicine services performed on an asymptomatic Covered Person, to the extent not already covered under this Plan as Clinical Preventive Services required under the Affordable Care Act (ACA).

Treatment, services, or supplies are only covered under this Preventive Medicine Services provision as part of a routine general medical examination when a Covered Person is symptom free, and has no reason to believe he/she might be unhealthy.

When Covered Charges are Incurred as part of an encounter for a general adult medical examination without abnormal findings, or when a laboratory examination is ordered as part of a routine general medical examination, preventive medicine services include the following:

1. General health panel.

2. Comprehensive metabolic panel (CMP).

3. Urinalysis (non-automated, with microscopy) by dip stick or tablet reagent for: bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, or any number of these constituents.

4. Urinalysis (non-automated, without microscopy) by dip stick or tablet reagent for: bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, or any number of these constituents.

5. Urinalysis (automated, without microscopy) by dip stick or tablet reagent for: bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, or any number of these constituents.

6. Prostate specific antigen (PSA) total.

7. Thyroid stimulating hormone (TSH).

8. Blood count — complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count.

If a Health Care Practitioner provides any of the treatment, services, or supplies noted above to a Covered Person who has risk factors, symptoms, or an established illness, such diagnostic medical care is not covered under this Preventive Medicine Services provision.

Diagnostic Imaging Services And Laboratory Services
Covered Charges Incurred for:

1. Diagnostic Imaging services and laboratory services.

2. Interpretation of Diagnostic Imaging services and laboratory tests, if a written report with interpretation is produced directly by the Health Care Practitioner.

3. Genetic testing to diagnose current symptoms of a potential hereditary disease.

Accident Medical Expense Benefit
This benefit only applies if the Benefit Summary indicates that the optional Accident Medical Expense Benefit is included in this Plan.

Covered Charges Incurred by a Covered Person for the treatment of an Accidental Injury are covered at 100% of Covered Charges, up to the amount shown in the Benefit Summary if:

1. The Injury occurs and Covered Charges are received while this Accident Medical Expense Benefit provision is in force; and

2. Covered Charges for treatment of the Injury are Incurred within the first 90 days after the date the Accident occurs.

Covered Charges in excess of the Accident Medical Expense Benefit shown in the Benefit Summary or Incurred more than 90 days after the date the Accident occurs will be paid subject to all the terms, limits and conditions in this Plan without regard to this Accident Medical Expense Benefit provision.

Outpatient Physical Medicine Services

Covered Charges Incurred for services listed below provided on an Outpatient basis in the Outpatient department of a Hospital, or in a Covered Person's home (by a licensed or certified agency).

Services must be rendered by a licensed speech therapist or pathologist, occupational or physical therapist, chiropractor, audiologist, doctor, psychologist, or social worker.

1. Physical Therapy, Occupational Therapy and Speech Therapy.

2. Pulmonary rehabilitation programs.

3. Adjustments and manipulations (i.e., chiropractic care).

4. Cardiac Rehabilitation Programs.

5. Services for treatment of Developmental Delay.

Covered Charges do not include services provided for educational purposes, services provided in a school setting, and educational services available to the Covered Person under local, state or federal law. Covered Charges do not include charges for services focused on developing or building communication skill or social interaction or protocol skills.

Coverage will cease when measurable and significant progress toward expected outcomes has been achieved or has plateaued as determined by the Plan. For laboratory services and Diagnostic Imaging services benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section.

Home Health Care Services
Covered Charges Incurred for:

1. Home Health Care visits by a licensed nurse.

2. Respiratory therapy.

3. Intravenous injectable parenteral drug therapy when authorized by the Plan to be paid under the Medical Benefits section.

4. Non-intravenous injectable drug therapy when authorized by the Plan to be paid under the Medical Benefits section.

Home Health Care must be provided by a Home Health Care Agency. One visit consists of up to 4 hours of care within a 24-hour period by anyone providing services or evaluating the need for Home Health Care. Limits of coverage are shown in the Benefit Summary.

The Plan may amend authorization for the treatment or frequency of care based on the Plan's Medical Necessity review of continued care. Coverage will cease when measurable and significant progress toward expected outcomes has been achieved or has plateaued, as determined by the Plan.

For insulin injection benefits, see the Outpatient Prescription Drug Benefits section.

Hospice Services
Covered Charges Incurred for:

1. The following Inpatient services when confined in a Hospice facility:

    a. Daily room and board.
    b. Part-time or intermittent nursing care by, or under the supervision of, a licensed registered nurse.
    c. Other Hospice services and supplies.

2. The following home care services when care is provided by a licensed Hospice:

    a. Part-time or intermittent nursing care by, or under the supervision of, a licensed registered nurse.
    b. Other Hospice services and supplies.
    c. Counseling services by a licensed Health Care Practitioner for each Immediate Family Member who is a Covered Person prior to another Covered Person's death.
    d. Bereavement counseling by a licensed Health Care Practitioner for each Immediate Family Member who is a Covered Person after another Covered Person's death.

    The covered counseling services listed above are not subject to the limitations for treatment of Behavioral Health or Substance Abuse.

Inpatient Rehabilitation Services
Covered Charges Incurred for services provided as an Inpatient in an Acute Medical Rehabilitation Facility that include, but are not limited to:

1. Rehabilitation Services provided for the same or a related Sickness or Injury that required an Inpatient Hospital stay.

2. Treatment of complications of the condition that required an Inpatient Hospital stay.

3. Physical Therapy, Occupational Therapy, and Speech Therapy.

4. Pulmonary rehabilitation programs.

5. The evaluation of the need for the services listed above.

The Plan may amend authorization for the treatment or frequency of care based on the Plan's Medical Necessity review of continued care. Coverage will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by the Plan.

Subacute Rehabilitation Facility And Skilled Nursing Facility Care
Covered Charges Incurred for services in a Subacute Rehabilitation Facility or a Skilled Nursing Facility that are:

1. Provided in lieu of care in a Hospital; or

2. For the same condition that required confinement in a Hospital and the Covered Person must enter the Subacute Rehabilitation Facility or Skilled Nursing Facility within 14 days after discharge from the Hospital after a confinement of at least 3 days.

The Plan may amend authorization for the treatment or frequency of care based on the Plan's Medical Necessity review of continued care. Coverage will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by the Plan.

Durable Medical Equipment And Personal Medical Equipment

Covered Charges Incurred for:

1. Rental or purchase, whichever is most cost effective as determined by the Plan, of the following items when prescribed by a Health Care Practitioner:

    a. A wheelc.hair.
    b. A basic Hospital bed.
    c. Basic crutches.

2. Casts, splints, trusses and orthopedic braces, excluding foot orthotics.

3. The temporary interim and initial permanent basic artificial limb or eye.

4. External breast prostheses needed because of surgical removal of all or part of the breast.

5. Oxygen and the equipment needed for the administration of oxygen.

6. The initial hair prosthesis worn for hair loss caused by: chemotherapy or radiation treatment for diagnosis of cancer; or diagnosis of alopecia areata.

7. Other Durable Medical Equipment and supplies that are approved in advance by the Plan.

Except as otherwise provided, charges for the replacement of the whole, or parts, of any of the items listed above are not covered, regardless of when the item was originally purchased. Except as otherwise provided, charges for the maintenance, repair, modification, or enhancement to the whole, or parts, of any of the items listed above are not covered, regardless of when the item was originally purchased.

Charges for replacement of, or maintenance, repair, modification or enhancement to, the whole or parts of wheelchairs will be covered when authorized by the Plan before any equipment is purchased.

Replacements due to outgrowing wheelchairs, Durable Medical Equipment, or Personal Medical Equipment as a result of the normal skeletal growth of a child will be covered when authorized by the Plan before any equipment is purchased.

Charges for duplicate Durable Medical Equipment, Personal Medical Equipment and supplies are not covered.

Maternity And Newborn Care Services
Covered Charges Incurred for:

1. Prenatal care. Any prenatal care in accordance with the A and B recommendations of the United States Preventive Services Task Force are considered under the Clinical Preventive Services provision.

2. Delivery, for a minimum of 48 hours of Inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of Inpatient care following an uncomplicated caesarean section delivery.

3. Postpartum care.

4. Routine well newborn care, including charges for general nursery care, from the moment of birth of a covered newborn Dependent child until the mother is discharged from the Hospital. Except for the delivery and/or routine nursery charges for which the provider submits the claims indicating the

mother as the Covered Person, the newborn Dependent child will be considered distinct from the mother for purposes of eligibility, coverage, and out-of-pocket expenses.

5. Complications of pregnancy.

Family Planning Services
The following services, to the extent not already covered under this Plan pursuant to the Clinical Preventive Services provision in this section:

1. Health Care Practitioner Office Visits for contraception management, including contraceptive education.

2. Services ordered by a Health Care Practitioner in relation to administration and dispensing of FDA-approved contraceptive Prescription Drugs or injections, or the fitting or dispensing of an IUD or diaphragm.

3. The insertion or removal of Norplant, or other similar device, by a Health Care Practitioner.

For oral contraceptive benefits, see the Outpatient Prescription Drug Benefits section.

Behavioral Health And Substance Abuse Services
The following services for treatment of Behavioral Health and Substance Abuse:

1. Inpatient services, when confined in an Acute Behavioral Health Inpatient Facility or a Behavioral Health Rehabilitation and Residential Facility.

2. Outpatient services, when care is received in an Intensive Outpatient Behavioral Health Program, a Partial Hospital and Day Treatment Behavioral Health Facility or Program, or in an office setting by a Health Care Practitioner who is licensed to treat Behavioral Health or Substance Abuse.

For benefits for drugs prescribed for the treatment of Behavioral Health and Substance Abuse, see the Outpatient Prescription Drug Benefits section.

Gene Therapy Services
Covered Charges Incurred for Gene Therapy treatment, diagnosis or supplies when care is received as Inpatient services when confined in a Hospital, or when care is received on an Outpatient basis when performed in a Hospital's Outpatient department, a Free-Standing Facility, or in a Physician's office.

Gene Therapy with Designated Gene Therapy Providers:
We have contracted with Designated Gene Therapy Providers to provide Gene Therapy services to Covered Persons at a Negotiated Rate.

To be covered under this Plan, Gene Therapy must be authorized by the Plan in accordance with the Utilization Review Provisions section. If the Covered Person decides to use a Participating Provider or Non-Participating Provider for Gene Therapy services instead of a Designated Gene Therapy Provider, benefits will not be covered.

For chimeric antigen receptor T-cell therapy (CAR T -Cell Therapy) benefits, please see the transplant benefits under the Inpatient Hospitalization Services provision.

Recuro Health Virtual Services

Covered Charges Incurred for a virtual visit which include services performed electronically, through Recuro Health medical providers or licensed therapists, outside of a medical facility. The virtual visit permits two-way, real-time interactive audio or audio and video communication between the Covered Person and a Health Care Practitioner at a distant location.

Covered Charges associated with a Recuro Health virtual visit are paid as shown in the Benefit Summary.

Please access the Recuro Health website at https://recurohealth.com/member-audience/ to receive additional information on virtual visits. You may call Recuro Health at 855-6RECURO.

Benefits for Telehealth Services provided by a Health Care Practitioner that is not a part of Recuro Health are covered under the Outpatient Medical Services benefit. Services rendered by other internet-based telehealth companies other than Recuro Health will not be considered Covered Charges and will not be paid.

Charges for Prescription Drugs prescribed during a Recuro Health Urgent Care Visit by the treating Recuro Health providers are covered under the Outpatient Prescription Drug Benefits section.

Recuro Health visits are not appropriate for a medical or Behavioral Health emergency. If You are experiencing a medical emergency or crisis situation, dial 911 immediately for assistance.

Vori Health® Services
Covered Charges Incurred for services performed electronically, through Vori Health providers, coaches, or therapist via the Vori Health virtual platform. A Vori Health visit permits two-way, real-time interactive audio and/or video communication between the Covered Person and a Vori Health provider at a distant location.

Covered Charges associated with Vori Health Services are paid as shown in the Benefit Summary. Please access the Vori Health website www.vorihealth.com/allstate for additional information on Vori Health Services. You may also call Vori Health at 1(866) 719-9611.

For purposes of this provision, services only include a Vori Health Evaluation or visits part of a Vori Health Treatment Plan on the Vori Health Virtual Platform.

Vori Health visits are not appropriate for a medical, mental health, or behavioral health emergency. If you are experiencing a medical emergency or crisis situation, dial 911 immediately for assistance.

Specialty Pharmaceutical Services
Covered Charges Incurred for Specialty Pharmaceuticals that are parenteral drugs, when they are administered, dispensed, or received on an Outpatient basis through a method other than self-administration. To be covered under this Plan, Specialty Pharmaceuticals must be authorized by the Plan in accordance with the Utilization Review Provisions.

For a Covered Person's first-time use of any Specialty Pharmaceutical, we may limit Our authorization to an initial 15 day treatment regimen. If the treatment regimen is continued, additional supply may be authorized.

If the Specialty Pharmaceutical is covered under this Medical Benefits section, any administration fees are covered under the Outpatient Medical Services provision in this section when the Specialty Pharmaceutical is received on an Outpatient basis through a method other than self-administration.

For insulin injection benefits, and benefits for Specialty Pharmaceuticals that are oral medications or which are obtained through a Pharmacy for self-administration, see the Outpatient Prescription Drug Benefits section.

VIII. OUTPATIENT PRESCRIPTION DRUG BENEFITS

You must obtain Prescription Drugs through a Participating Pharmacy to receive the Outpatient Prescription Drug Benefits available under this Plan. Prescription Drugs obtained from a Non-Participating Pharmacy are not covered. Read the Provider Charges and Maximum Allowable Amount Provisions section of this Plan carefully.

Only the Prescription Drugs listed on the Drug List, obtained through a provider participating in the Health Care Provider Network, and received in accordance with this section of the SPD will be considered Covered Charges. How Covered Charges are paid, and the maximum benefit for the covered Prescription Drugs listed in this section, are shown in the Benefit Summary. Refer to the exclusions section of the SPD for drugs, medications and supplies that are not covered under this Plan.

The Covered Person must follow the Utilization Review provisions section and use the Participating Pharmacy Network or Specialty Pharmacy Network to receive the maximum benefits available under this Plan. Outpatient Prescription Drug Benefits will not be paid for any Specialty Pharmaceuticals which are obtained through a Pharmacy for self-administration that are not authorized by the Plan in accordance with any applicable Specialty Pharmacy Program.

Prior authorization may be required for certain Prescription Drugs before they are considered for coverage under the Outpatient Prescription Drug Benefits section. Please access the Pharmacy benefit website listed on your Identification (ID) Card to receive information on which Prescription Drugs require prior authorization, to check Prescription Drug coverage and pricing, or to locate a Participating Pharmacy.

After the Covered Person has paid any applicable Ancillary Charge, Ancillary Pharmacy Network Charge, Coinsurance, Copayment, Deductible, Prescription Drug Coinsurance, Prescription Drug Copayment, Prescription Drug Deductible, or any other applicable fees, benefits will be paid by the Plan for Covered Charges for Outpatient Prescription Drugs listed in this section of the SPD. Any applicable Coinsurance, Copayment, Deductible Prescription Drug Coinsurance, Prescription Drug Copayment, Prescription Drug Deductible, or other fees, and the Prescription Drug Class to which they apply are shown in the Benefit Summary. Benefits paid under this section are subject to any Maximum Benefit for Prescription Drugs provided under this Plan. Benefits are subject to all the terms, limits, and conditions in this SPD.

Any Ancillary Charge, or Ancillary Pharmacy Network Charge, under this section will not apply toward satisfying any Coinsurance, Copayment, Deductible or Out-of-Pocket Limit under this Plan.

Unless a Prescription Drug is specifically listed as a Covered Charge in the Medical Benefits section, all Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section. Any amount in excess of the maximum amount provided under this section is not covered under any other section of this SPD. Expenses Incurred under this section apply toward any applicable Out-of-Pocket Limits under this SPD, as shown in the Benefit Summary.

Drug List
Only the Prescription Drugs listed on the Drug List are eligible for Outpatient Prescription Drug benefits under this Plan. Drugs not on the Drug List on the date obtained are not covered. Prescription Drugs are covered only if all active ingredients are covered under this Plan. The Drug List is subject to change. For example, when new drugs come to market or when a generic version of a drug comes to market, the Drug List may be expanded or revised related to the Brand Name and Generic version of that drug. Review the

current Drug List prior to obtaining Your Prescription Drug. Discuss cost effective treatments with Your doctor. The Drug List website is shown on Your Benefit Summary. Your Benefit Summary shows Your required share in the cost of Prescription Drugs.

The Drug List includes certain contraceptive Prescription Drugs and products, as identified in accordance with the Affordable Care Act. For injectable contraceptives and contraceptive implants, see the Clinical Preventive Services or Preventive Medicine Services provisions of the Medical Benefits section.

The Drug List includes certain Clinical Preventive Services Medications And Products, as identified in accordance with the Affordable Care Act.

Cost Difference Between Generic Drugs and Brand Name Drugs
If a Covered Person obtains a Brand Name Drug when a Generic Drug or Bio-Similar Drug is available and on the Drug List, the Covered Person must pay the difference in cost between the Brand Name Drug and the Generic Drug or Bio-Similar Drug (the "Ancillary Charge"), in addition to any applicable Copayment, Coinsurance, and Deductible for the Brand Name Drug.

In rare cases there may be potential bioequivalence inconsistencies between the Brand Name Drug and its generic version. Such drug categories are: digitalis glycosides, antiepileptic drugs, antiarrhythmic agents, conjugated estrogens, esterified estrogens, warfarin anticoagulants, theophylline products, and thyroid preparations. In these cases, if the Covered Person's physician provides documentation that the Generic Drug is demonstrated to have lesser or adverse therapeutic effect or potential for the Covered Person, the Plan will approve the Ancillary Charge as Covered Charges. The Covered Person should call the Plan to request a review of the Covered Person's Prescription Drug in such cases.

Any Ancillary Charge will not count toward satisfying any Coinsurance, Copayment, Out-of-Pocket Limit, or Deductible under this Plan.

Step Therapy
When alternative Prescription Drug treatments are available, the Plan considers Covered Charges for Prescription Drugs in accordance with Our Drug List for the most cost-effective option. Before the Plan authorizes coverage of a particular Prescription Drug, the Plan may require the Covered Person's Health Care Practitioner to prescribe one or more different Prescription Drugs first, unless all such other Prescription Drugs have been demonstrated to be clinically: 1) adverse or 2) non-effective for the Covered Person. Requiring a particular drug or drugs to be prescribed and attempted first before authorizing a different drug is called step therapy. Even if the Covered Person had previously taken the Prescription Drug being requested, the Plan may require step therapy under this Plan. The step therapy could include changes to the dosage of the Prescription Drug or substituting the Prescription Drug with a different drug(s) or drug regimen in the same or similar therapeutic classification. Covered Persons should call the Plan to discuss options available to them. An Ancillary Charge may still apply.

Supply Limits
This Plan provides benefits only for the following Covered Charges for Prescription Drugs that are received on an Outpatient basis:

1. Up to a 30 consecutive day supply for each Prescription Order, unless restricted to a lesser amount by the Prescription Order, the manufacturers' packaging or any limitations in this Plan. If a 90-Day Prescription Drug Provider is used, the Plan will pay up to a 90 consecutive day supply for each Prescription Order for Prescription Maintenance Drugs covered by and through the 90-Day Prescription Drug Provider, unless restricted to a lesser amount by the Prescription Order, the manufacturer's packaging, additional dispensing limitations or other limitations in this Plan.

2. Up to 3 vials or up to a 30 consecutive day supply of one type of self-injectable insulin for each Prescription Order, whichever is less. If a 90-Day Prescription Drug Provider is used, the Plan will pay up to 9 vials or up to a 90 consecutive day supply of one type of insulin for each Prescription Order, whichever is less.

3. Up to 100 disposable insulin syringes and needles, up to 100 disposable blood/urine/glucose/acetone testing agents, or up to 100 lancets, or up to a 30 consecutive day supply for each Prescription Order, whichever is less. If a 90-Day Prescription Drug Provider is used, the Plan will pay up to 300 disposable insulin syringes and needles or up to 300 disposable blood/urine/glucose/acetone testing agents or up to 300 lancets, or up to a 90 consecutive day supply for each Prescription Order, whichever is less.

4. Prescription Drugs, in dosages, dosage forms, dosage regimens and durations of treatment that are Medically Necessary for the treatment of a Sickness or an Injury that is covered under this Plan.

5. Prescription Drugs that are within the quantity, supply, cost-sharing or other limits that the Plan determines are appropriate for a Prescription Drug. Prescription Drugs are limited to maximum daily doses of medications that are approved by the FDA and/or supported by peer reviewed literature or sound scientific principles.

Manufacturer's Packaging Limits
Some Prescription Drugs may be subject to additional supply, quantity, duration, gender, age, lifetime, cost sharing or other limits based on the manufacturer's packaging, Plan limits or the Prescription Order. Examples of these situations are:

1. If a Prescription Drug is taken on an as-needed basis, only enough medication for a single episode of care may be covered per dispensation; and

2. If two or more covered Prescription Drug products are packaged and/or manufactured together, the Covered Person may be required to pay any applicable Prescription Drug Copayment, Deductible or the Coinsurance amount, as specified for each of the Prescription Drug products contained in the packaging and/or in the combination Prescription Drug product; or

3. If two or more Prescription Drug products are packaged and/or manufactured together and one or more of the active ingredients in the products are not covered, then the entire packaged and/or manufactured combination product is not covered under this Plan.

Any Prescription Drug which is a metabolite, isomer, extended release or other dosage form, unique salt or other formulation, or other direct or indirect derivative of a Prescription Drug approved by the FDA may be subject to similar terms, limits and conditions of coverage or will not be covered by this Plan if the original drug would not be covered.

Payment of Benefits
Participating Pharmacy
Present Your identification (ID) card to the Participating Pharmacy to obtain benefits. The Covered Person must pay any applicable Coinsurance or Deductible under the Medical Benefits section, Prescription Drug Coinsurance, Prescription Drug Copayment and/or Prescription Drug Deductible, or Ancillary Charge to the Participating Pharmacy. The following additional cost sharing provisions apply to covered Outpatient Prescription Drugs purchased at a Participating Pharmacy when the ID card is used to obtain benefits:

1. When a covered Generic Drug is available and that Generic Drug is received, the Covered Person pays the Prescription Drug Copayment for that Generic Drug.

2. When a Generic Drug is not available and a Brand Name Drug is received, the Covered Person pays the Prescription Drug Copayment for that Brand Name Drug.

3. If a Brand Name Drug is received when a Generic Drug or Bio-Similar Drug is available, the Covered Person pays the Prescription Drug Copayment for that Brand Name Drug. The Covered Person must pay the difference in the Contracted Rate between the cost of the Brand Name Drug and the Generic Drug. The difference in the Contracted Rate between the two drugs will not be reimbursed by the Plan nor does it count toward satisfying any Coinsurance, Deductible or other Out-of-Pocket Limit.

If the Covered Person does not use the ID card to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay for the Prescription Drugs in full at the Participating Pharmacy. To receive reimbursement for Covered Charges, the Covered Person must file a claim with the Plan, as explained in the How To File A Claim provision in this section. The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy for the cost of the covered Prescription Drug minus any applicable Ancillary Charge, Ancillary Pharmacy Network Charge, Prescription Drug Coinsurance, Coinsurance, Prescription Drug Copayment, Prescription Drug Deductible, and/or Deductible. Any Ancillary Charge, Ancillary Pharmacy Network Charge, Coinsurance, Prescription Drug Copayment, Prescription Drug Deductible, Prescription Drug Coinsurance, and/or any amounts not paid by the Plan due to the difference between the billed amount for the Prescription Drug and the Plan's benefit payment, do not count toward satisfying any Coinsurance, Copayment, Deductible, or Out-of-Pocket Limit under the Medical Benefits section.

Specialty Pharmaceuticals
Most Specialty Pharmaceuticals that are parenteral drugs, which are received on an Outpatient basis through a method other than self-administration, are covered under the Medical Benefits section; call the Plan Administrator to verify benefits.

For coverage under this Outpatient Prescription Drug Benefits section for any Specialty Pharmaceuticals that are obtained through a Pharmacy for self-administration, a Covered Person must obtain authorization before the Specialty Pharmaceutical is considered for possible coverage. Participating in a Specialty Pharmacy Program may also be required for coverage. If the Specialty Pharmaceutical is authorized, the Covered Person will be advised how the Specialty Pharmaceutical can be obtained from a Specialty Pharmacy Provider and how to file a claim.

For a Covered Person's first-time use of any Specialty Pharmaceutical, we may limit Our authorization to an initial 15-day treatment regimen. If the treatment regimen is continued, additional supply may be authorized.

If a Specialty Pharmaceutical is covered under this Outpatient Prescription Drugs Benefits section, and the Covered Person has Specialty Pharmaceutical Prescription Drugs filled at a Pharmacy that is not a Specialty Pharmacy Provider, the Covered Person must pay for the Specialty Pharmaceutical Prescription Drug in full at the Pharmacy. The Covered Person will not be reimbursed.

Under this Outpatient Prescription Drugs Benefits section, Covered Charges Incurred for Specialty Pharmaceutical Prescription Drugs obtained from a Pharmacy that is not a Specialty Pharmacy Provider are not covered, and will not apply toward satisfying any Out-of-Pocket Limit.

Non-Participating Pharmacy

If the Covered Person has prescriptions filled at a Non-Participating Pharmacy, the Covered Person must pay for the Prescription Drug in full at the Non-Participating Pharmacy. The Covered Person will not be reimbursed.

90-Day Prescription Drug Provider
Coverage for 90-day Prescription Orders of selected Outpatient Prescription Maintenance Drugs may be available to You and Your Covered Dependents under this Plan as shown in the Benefit Summary. If this service is available, You will be advised of the name and address of the 90-Day Prescription Drug Provider so that You and Your Covered Dependents can take advantage of this service. Order forms may be obtained from the Employer or by contacting the Plan. If the 90-Day Prescription Drug Provider is a Mail Service Prescription Drug Vendor and You choose home delivery of Prescription Maintenance Drugs, the Covered Person must mail the Prescription Order, a completed order form and any required cost sharing amounts to the Mail Service Prescription Drug Vendor.

The following Prescription Drug Copayment cost sharing provisions apply to covered Outpatient Prescription Maintenance Drugs that are obtained through a 90-Day Prescription Drug Provider:

1. When a covered Generic Drug is available and that Generic Drug is received, the Covered Person pays the applicable 90-Day Prescription Drug Provider Copayment for that Generic Drug.

2. When a Generic Drug is not available and a Brand Name Drug is received, the Covered Person pays the applicable 90-Day Prescription Drug Provider Copayment for that Brand Name Drug.

3. If a Brand Name Drug is received when a Generic Drug or Bio-Similar Drug is available, the Covered Person pays the 90-Day Prescription Drug Provider Copayment. The Covered Person must pay the difference in the Contracted Rate between the cost of the Brand Name Drug and the Generic Drug. The difference in the Contracted Rate between the two drugs will not be reimbursed by the Plan nor does it count toward satisfying any Coinsurance, Deductible or other Out-of-Pocket Limit under the Plan.

4. When a covered Prescription Drug is available under two or more names, dosages, dosage forms, dosage regimens or manufacturers' packaging or when more than one covered Prescription Drug may be used to treat a condition that would be covered under this Plan, the Plan will consider benefits only for the most cost effective drug, dosage form or packaging that would be a Covered Charge under this Plan and that will produce a professionally adequate result.

When using a Mail Service Prescription Drug Vendor, the vendor will fill the covered Prescription Order and mail it along with a replacement order form to the Covered Person. It will be mailed to the Covered Person’s home or another location that is designated by the Covered Person. Some medications may have shipping restrictions.

Identification Cards
In connection with this benefit, You will receive an identification (ID) card for You and Your Covered Dependents to use while covered under this Plan.

No benefits are payable for any Prescription Order filled for a Covered Person on or after the date his or her coverage terminates under this Plan. Thus, all Covered Persons are required to turn in their ID card or cards to the Plan at the time of coverage termination. If You fail to do so and any Covered Person uses the ID card after coverage ends, You are responsible for all Prescription Drugs purchased after the termination date. We will recover from You any amounts paid by the Plan for drugs purchased after coverage terminates under this Plan.

How To File A Claim
Present Your ID card with the Prescription Order at the Pharmacy each time a Prescription Order is filled at a Participating Pharmacy. Pay the Participating Pharmacy the difference between the charge for the covered Prescription Drug and the amount the Plan will pay. This applies to each covered Prescription Drug that is filled at a Participating Pharmacy. If the ID card is not used to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay the Participating Pharmacy the entire amount charged for the covered Prescription Drug. Complete a prescription drug claim form. Send it and any Prescription Drug receipts to the Prescription Card Service Administrator (PCSA) at the address shown on the form for reimbursement of Covered Charges. A prescription drug claim form can be obtained from the Plan.

Miscellaneous Provisions
The amount paid by the Plan under this section may not reflect the ultimate cost for the Prescription Drug. Any amounts that the Covered Person is responsible for paying are paid on a per prescription or refill basis and will not be adjusted if any retrospective volume drug discounts or Prescription Drug rebates under any portion of this Plan are received.

Manufacturer product discounts, also known as rebates, may be provided and may be related to certain drug purchases under this Plan. These amounts will not be refunded to You.

Payment by the Plan for a Prescription Drug under this section does not constitute any assumption of liability for coverage of a Sickness or an Injury under the Medical Benefits section. It also does not constitute any assumption of liability for further coverage of the Prescription Drug under this section.

For the purpose of the Coordination Of Benefits section, the Outpatient Prescription Drug Benefits section will be considered a separate medical plan, as defined in the Coordination Of Benefit section, and will be coordinated only with other Prescription Drug coverage. We will not provide any benefits for Prescription Drug charges that are paid by another medical plan defined in the Coordination Of Benefit section as the primary payor.

The Covered Person is responsible for any Prescription Drug Coinsurance, Coinsurance, Prescription Drug Copayment, Prescription Drug Deductible, and/or Deductible that is paid for a Prescription Order that is filled, regardless of whether the Prescription Order is revoked or changed due to adverse reaction or changes in dosage, dosage regimen, or Prescription Order. These charges will not be reimbursed by the Plan.

IX. EXCLUSIONS

We will not pay benefits for any of the following:

1. Charges that do not meet the definition of a Covered Charge in this Plan including, but not limited to:

    a. Charges in excess of the Maximum Allowable Amount, as determined under this Plan.
    b. Charges that are not Medically Necessary.
    c. Charges that exceed Plan parameters.

2. Charges for any amount in excess of any maximum benefit for covered services.

3. Charges for claims deemed denied on account of failure of the Covered Person, or the provider to whom the Covered Person assigned benefits, to redeem claim payment within 12 months following the issue date of such payment.

4. Charges that are provided or performed by a Health Care Practitioner, facility, or supplier that is not identified for this Plan by the Health Care Provider Network as a Participating Pharmacy, Specialty Pharmacy Provider, or, Designated Transplant Provider, except as otherwise specified under this Plan.

5. Charges for which the Plan's liability cannot be determined because a Covered Person, Health Care Practitioner, facility, or other individual or entity within 30 days of the Plan's request, failed to:

    a. Authorize the release of all medical records to the Plan and other information the Plan requested.
    b. Provide the Plan with information the Plan requested about pending claims, other insurance coverage or proof of Creditable Coverage.
    c. Provide the Plan with information that is accurate and complete.
    d. Have any examination completed as the Plan requested.
    e. Provide reasonable cooperation to any requests made by the Plan.

6. Charges that:

    a. Are complications of a non-covered service.
    b. Are Incurred before the Covered Person's Effective Date or after the termination date of coverage, except as provided under any Extension of Benefits provision.
    c. Are not documented in the Health Care Practitioner's or Medical Supply Provider's records.
    d. Are related to the supervision of laboratory services that do not involve written consultation by a Health Care Practitioner including, but not limited to, laboratory interpretation.
    e. Are complications resulting from leaving a licensed medical facility against the advice of the Covered Person's Health Care Practitioner.

7. Charges that are:

    a. Payable or reimbursable by Medicare Part A, Part B or Part D, where permitted by law.
    b. Payable or reimbursable by any other government law or program, except Medicaid (Medi-Cal in California).
    c. For free treatment provided in a federal, veteran's, state or municipal medical facility.
    d. For free services provided in a student health center.
    e. For services that a Covered Person has no legal obligation to pay or for which no charge would be made if the Covered Person did not have a health plan or insurance coverage.

8. Charges for particular treatment, services, supplies or drugs for which the Plan is billed by a provider who waives or reduces the Covered Person's payment obligation of any Copayment, Coinsurance and/or Deductible amounts for such treatment, services, supplies or drugs.

9. Charges for work-related Sickness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when the Covered Person does not file a claim for benefits. Sickness or Injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to any of the following:

    a. The sole proprietor, if the Covered Person's employer is a proprietorship.
    b. A partner of the Covered Person's employer, if the employer is a partnership.
    c. An executive officer of the covered person's employer, if the employer is a corporation.

10. Charges for which a Covered Person is entitled to payment under any motor vehicle medical payment or premises medical expense coverage. Coverage under this Plan is secondary to medical payment or medical expense coverage available to the Covered Person, regardless of whether such other coverage is described as secondary or contingent.

11. Charges caused by or contributed to by:

    a. War or any act of war, whether declared or undeclared.
    b. Participation in the military service of any country or international organization, including non-military units supporting such forces.

12. Charges for:

    a. Vision care that is routine, except as otherwise covered in the Diabetic Services, Clinical Preventive Services, or Preventive Medicine Services provisions in the Medical Benefits section.
    b. Gene therapy for vision loss.
    c. Glasses or contact lenses, except when used to aid in healing an eye or eyes due to a Sickness or an Injury (other than aphakia).
    d. Vision therapy, exercise or training.
    e. Glasses used to correct aphakia.
    f. Surgery, including any complications arising therefrom, to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services, or surgery to correct astigmatism, nearsightedness (myopia), and/or farsightedness (presbyopia).

13. Charges for Gene Therapy for treatment of blindness, vision loss, inherited retinal diseases or conditions, age-related macular degeneration, diabetic macular edema, corneal eye disease, or any other eye disease or disorder.

14. Charges for Gene Therapy services:

    a. Rendered by a provider that is not a Designated Gene Therapy Provider.
    b. That are not authorized by the Medical Review Manager before services are rendered.

15. Charges for:

    a. Hearing care that is routine, except as otherwise covered in the Clinical Preventive Services or Preventive Medicine Services provisions in the Medical Benefits section.

b. Any artificial hearing device, cochlear implant, auditory prostheses, or other electrical, digital, mechanical, or surgical means of enhancing, creating, or restoring auditory comprehension.

16. Charges for foot conditions, including, but not limited to, expenses for:

    a. Foot supportive devices, including orthotics and corrective shoes, except those included as part of a Medically Necessary orthopedic brace otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision in the Medical Benefits section.
    b. Foot subluxation treatment.
    c. Care of corns; bunions; hammertoe; calluses; toenails; fallen arches; weak feet; chronic foot strain; or symptomatic complaints of the feet.
    d. Hygienic foot care that is routine, except as otherwise covered in the diabetic services provision in the Medical Benefits section.

17. Except as otherwise covered in the dental services provision in the Medical Benefits section, charges for:

    a. Dental charges.
    b. Dental care that is routine.
    c. Bridges, crowns, caps, dentures, dental implants, or other dental prostheses.
    d. Dental braces or dental appliances.
    e. Extraction of teeth.
    f. Orthodontic charges.
    g. Odontogenic cysts.
    h. Any other expenses for treatment to, or complications of, the teeth and gum tissue.

18. Charges for treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction, except as otherwise covered in the Temporomandibular Joint (TMJ) Or Craniomandibular Joint (CMJ) Dysfunction provision in the Medical Benefits section, which include, but are not limited to:

    a. Any electronic diagnostic modalities.
    b. Occlusal analysis.
    c. Muscle testing.

19. Charges for any appliance, medical or surgical expenses for:

    a. Malocclusion, or Mandibular Protrusion Or Recession.
    b. Maxillary Or Mandibular Hyperplasia.
    c. Maxillary Or Mandibular Hypoplasia.

20. Charges for:

    a. Any diagnosis, supplies, treatment, or regimen (whether medical or surgical) for purposes of controlling the Covered Person's weight, or related to obesity or morbid obesity, whether or not weight reduction is Medically Necessary or appropriate, or regardless of potential benefits for co-morbid conditions.
    b. Weight reduction or weight control surgery, treatment, or programs.
    c. Any type of gastric bypass surgery.
    d. Suction lipectomy.
    e. Physical fitness programs, exercise equipment, or exercise therapy, including health club membership fees or services.

f. Nutritional counseling, except as otherwise covered in the Outpatient Medical Services, Clinical Preventive Services, or Preventive Medicine Services provisions in the Medical Benefits section.

21. Charges for Transplant services that are:

    a. Authorized by the Plan to treat a specific medical condition if they are performed to treat a different medical condition that would not have been authorized.
    b. Not specifically listed as a covered transplant in the Inpatient Hospitalization Services provision in the Medical Benefits section.
    c. For any non-human (including animal or mechanical) to human organ transplant.
    d. For the purchase price of an organ or tissue that is sold rather than donated.

22. Charges for:

    a. Cosmetic Services, including, but not limited to: chemical peels; cosmetic treatment of varicose veins; and, reconstructive or plastic surgery that does not alleviate a functional impairment.
    b. Other charges that are primarily a Cosmetic Service, except as otherwise covered in the Outpatient Medical Services provision in the Medical Benefits section.

23. Except as otherwise covered in the Outpatient Medical Services provision in the Medical Benefits section, charges for:

    a. Revision of breast surgery for capsular contraction.
    b. Removal, or replacement, of a prosthesis.
    c. Augmentation or reduction mammoplasty.

24. Charges for prophylactic treatment, services, or surgery including, but not limited to: prophylactic mastectomy; or, any other treatment, services, or surgery performed to prevent a disease process from becoming evident in the organ or tissue at a later date.

    This does not apply to prophylactic mastectomy/hysterectomy (oophorectomy) if the Covered Person has tested positive for BRCA gene and the Covered Person meets the Plan's medical policies for prophylactic treatment.

25. Charges for:

    a. A private duty nurse; a private duty professional skilled nursing service; a masseur, masseuse, or massage therapist; a rolfer; a home health aide, or personnel with similar training and experience; or, a stand-by Health Care Practitioner, except as otherwise covered in the Outpatient Physical Medicine provision in the Medical Benefits Section.
    b. Custodial Care; respite care; rest care; supportive care; or, homemaker services.
    c. A Health Care Practitioner who is not properly licensed or authorized in the state where services are rendered.
    d. Phone consultations; internet consultations; e-mail consultations, except for Telehealth (virtual) visits or as otherwise covered in the Recuro Health Virtual Services and Vori Health Services provision in the Medical Benefits Section.
    e. Provider administrative expenses including, but not limited to: expenses for claim filing, contacting utilization review organizations, or case management fees.
    f. Missed appointments or cancellation fees.
    g. Sales tax or gross receipt tax.
    h. Living expenses; travel; or transportation, except as otherwise covered in the Emergency and Ambulance Services provision or transplants provision in the Medical Benefits section.

i. Treatment or services that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider.

26. Charges for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth, except as otherwise covered in the Growth Hormone Therapy Services provision in the Medical Benefits section.

27. Charges related to the following conditions, regardless of underlying causes: treatment of sexual function, dysfunction or inadequacy; or, treatment to enhance, restore or improve sexual energy, performance or desire.

28. Charges for or related to non-spontaneous abortion.

29. Charges for elective caesarean section.

30. Charges for:

    a. Genetic testing and genetic counseling, services and related procedures for screening purposes, except for BRCA screening, counseling and testing in accordance with USPSTF A and B recommendations, except as otherwise covered in the Medical Benefits section.
    b. Amniocentesis, in excess of 1 Medically Necessary procedure per pregnancy.
    c. Chorionic villi testing.
    d. Sterilization, except as otherwise covered in the Clinical Preventive Services provision in the Medical Benefits section.

31. Charges for:

    a. Reversal of voluntary reproductive sterilization, for males or females, and related tests.
    b. Infertility services when the infertility is caused by, or related to, voluntary reproductive sterilization.
    c. Donor charges and services for infertility treatment.
    d. Any experimental, investigational or unproven infertility procedures or therapies.
    e. Cryopreservation of sperm, embryo or eggs.
    f. Surrogate pregnancy.
    g. Umbilical cord stem cell, or other blood component, harvest and storage in the absence of a Sickness or an Injury.

32. Charges for chelation therapy, except for laboratory proven toxic states as defined by peer-reviewed published studies.

33. Charges Incurred for Experimental Or Investigational Services, except for Routine Patient Costs in an Approved Clinical Trial.

34. Charges Incurred outside of the United States and its territories, except for services that are received for Emergency Treatment.

35. Charges related to Health Care Practitioner assisted suicide.

36. Charges for venipuncture, specimen collection, and lab handling fees.

37. Charges for infertility diagnosis and treatment for males or females including, but not limited to:

    a. Services of an embryologist.
    b. Drugs and medications administered by a Health Care Practitioner.
    c. Surgeries and other therapeutic procedures to promote conception.
    d. Laboratory tests.
    e. Sperm washing or preparation.
    f. Artificial insemination.
    g. Diagnostic evaluations, and related tests, services, or procedures.
    h. Gamete intrafallopian transfer (GIFT).
    i. In vitro fertilization (IVF).
    j. Zygote intrafallopian transfer (ZIFT).

38. Charges for cranial orthotic devices that are used to redirect growth of the skull bones or reduce cranial asymmetry, except following cranial surgery.

39. Except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or the diabetic services provision in the Medical Benefits section, charges for:

    a. Home traction units.
    b. Home defibrillators.
    c. Other medical devices designed to be used at home.

40. Charges to address quality of life or lifestyle concerns and similar charges for non-functional conditions, except as otherwise covered in the Clinical Preventive Services or Preventive Medicine Services provisions in the Medical Benefits section.

41. Charges for:

    a. Services to address behavioral (conduct) problems.
    b. Services to build communication or social interaction or protocol skills.
    c. Services to address learning disabilities.
    d. Educational testing, training or materials.
    e. Services to address cognitive enhancement, learning or training.
    f. Training for activities of daily living.

42. Charges for applied behavior analysis.

43. Charges for:

    a. Vocational or work hardening programs.
    b. Transitional living.

44. Charges for services provided by or through a school system.

45. Charges for preventive care, except as otherwise covered in the Clinical Preventive Services or Preventive Medicine Services provisions in the Medical Benefits section.

46. Charges for:

    a. Non-medical items, self-care or self-help programs.
    b. Aroma therapy.

c. Acupuncture.
d. Meditation or relaxation therapy.
e. Naturopathic medicine
f. Homeopathic medicine.
g. Treatment of hyperhidrosis (excessive sweating).
h. Biofeedback; neurotherapy; electrical stimulation; or Aversion Therapy.
i. Inpatient treatment of chronic pain disorders, except as Medically Necessary.
j. Smoking cessation, except as otherwise covered in the Clinical Preventive Services or Preventive Medicine Services provisions in the Medical Benefits section.
k. Treatment or evaluation of snoring.
l. The treatment or prevention of hair loss.
m. Change in skin pigmentation.
n. Stress management.
o. Massage therapy, except when approved as part of an authorized physical therapy regimen.
p. Marriage counseling.

47. Charges for treatment or services Incurred due to Sickness or Injury of which a contributing cause was the Covered Person's voluntary attempt to commit, participation in, or commission of, a felony, whether or not charged.

48. Charges for treatment or services required due to Injury received while engaging in any hazardous occupation or other activity for which compensation is received including, but not limited to, the following:

    a. Participating, or instructing, or demonstrating, or guiding, or accompanying others, in parachute jumping.
    b. Participating, or instructing, or demonstrating, or guiding, or accompanying others, in hang-gliding.
    c. Participating, or instructing, or demonstrating, or guiding, or accompanying others, in bungee jumping.
    d. Racing any motorized or non-motorized vehicle,
    e. Skiing.
    f. Rodeo activities.

    Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning, or physical preparation for any such compensated activity.

49. Charges for Prescription Drugs, medications, or other substances dispensed or administered in an Outpatient setting, except as otherwise covered in this Plan.

50. Charges for drugs and medicines prescribed for treatment of a Sickness or an Injury that is not covered under this Plan.

51. Charges for:

    a. Drugs that have not been fully approved by the FDA for marketing in the United States.
    b. Drugs limited by federal law to investigational use.
    c. Drugs that are used for Experimental Or Investigational Services, even when a charge is made.
    d. Drugs with no FDA-approved indications for use.
    e. FDA approved drugs used for indications, dosage, or dosage regimens outside of FDA approval.
    f. FDA approved drugs used for administration outside of FDA approval.

g. Drugs that are undergoing a review period, not to exceed 12 months, following FDA approval of the drug for use and release into the market.
h. Drugs determined by the FDA as lacking in substantial evidence of effectiveness for a particular condition, disease, or for symptom control.

This exclusion does not apply to the Routine Patient Costs a Clinical Trial Qualified Individual incurs while participating in an Approved Clinical Trial.

52. Charges for vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner except for:

    a. Legend prenatal vitamin Prescription Drugs when the prenatal vitamins are prescribed during pregnancy.
    b. Clinically proven vitamin deficiency syndromes that cannot be corrected by dietary intake.
    c. Vitamins covered in accordance with the Clinical Preventive Services or Preventive Medicine Services provisions of the Medical Benefits section.

53. Charges for any over-the-counter or prescription products, drugs, or medications in the following categories, whether or not prescribed by a Health Care Practitioner:

    a. Herbal or homeopathic medicines or products.
    b. Minerals.
    c. Health and beauty aids.
    d. Batteries.
    e. Appetite suppressants.
    f. Dietary or nutritional substances or dietary supplements.
    g. Nutraceuticals.
    h. Tube feeding formulas and infant formulas, except as otherwise covered in the Clinical Preventive Services or Preventive Medicine Services provisions in the Medical Benefits section.
    i. Medical foods.

54. Charges for any over-the-counter drugs or medications in the following categories, whether or not prescribed by a Health Care Practitioner:

    a. NSAID's.
    b. H2 Antagonists.
    c. Laxatives.
    d. Protectants.
    e. PPI's.
    f. Antihistamines.

55. Charges for drugs and medicines, unless dispensed or administered at the same time a covered service is provided under the Medical Benefits section.

56. Charges for drugs, medications, or other substances that are illegal under federal law, such as marijuana, even if they are prescribed for a medical use in a state. This includes, but is not limited to, items dispensed by a Health Care Practitioner.

57. Charges for drugs obtained from pharmacy provider sources outside the United States, except as otherwise covered in the Medical Benefits section.

58. Charges for any injectable medications or Specialty Pharmaceuticals that are not specifically authorized by the Plan under the Medical Benefits section or charges for any injectable medications or Specialty Pharmaceuticals that are not specifically authorized by the Plan under the Outpatient Prescription Drug Benefits section.

59. Charges for:

    a. Drugs dispensed at or by a Health Care Practitioner's office, clinic, hospital or other non-pharmacy setting for take home by the Covered Person.
    b. Amounts above the Contracted Rate for Participating Pharmacy or Specialty Pharmacy Provider reimbursement.
    c. The difference between the cost of the Prescription Order at a Non-Participating Pharmacy and the Contracted Rate that would have been paid for the same Prescription Order had a Participating Pharmacy or Specialty Pharmacy Provider been used.
    d. Any administrative charges for any other drugs.

60. Specialty Pharmaceuticals not on the Drug List.

61. Unless determined to be Medically Necessary, charges for any court-ordered:

    a. Hospitalization for evaluation.
    b. Inpatient civil commitment.
    c. Assisted Outpatient Treatment (AOT).
    d. Outpatient commitment.
    e. Mandated Outpatient treatment.

62. Charges for services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is an Immediate Family Member, or a person who ordinarily resides with a Covered Person.

63. Services provided by the Covered Person's Immediate Family Member or anyone residing with the Covered Person.

64. Charges for treatment, services, supplies or drugs provided by or through any employer of a Covered Person or the employer of a Covered Person's family member.

    For purposes of this exclusion, "employer" includes but is not limited to any corporation, partnership, sole-proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer. "Employer" also includes any other affiliated providers in which there is common ownership between such providers and the "employer."

65. Charges for treatment, services, supplies or drugs provided by or through any entity in which a Covered Person or their family member receives, or is entitled to receive, any direct or indirect financial benefit, including but not limited to an ownership interest in any such entity.

    For purposes of this exclusion, "entity" includes but is not limited to any corporation, organization, partnership, sole-proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.

In addition to the exclusions listed above, the following additional exclusions apply only to the Outpatient Prescription Drug Benefits section. The Plan will not pay benefits for any of the following:

1. Charges for drugs that are provided by, or obtained through, a Pharmacy that is not identified for this Plan by the Health Care Provider Network as a Participating Pharmacy or Specialty Pharmacy Provider.

2. Charges for drugs not on the Drug List.

3. Charges for that part of any Prescription Order exceeding a 30 consecutive day supply per Prescription Order.

4. Charges for that part of any Prescription Order exceeding a 90 consecutive day supply if the Prescription Drug is dispensed through a 90-Day Prescription Drug Provider.

5. Charges for that part of any Prescription Order exceeding 3 vials or a 30 consecutive day supply of one type of insulin.

6. Charges for that part of any Prescription Order exceeding 9 vials or a 90 consecutive day supply of one type of insulin if it is dispensed through a 90-Day Prescription Drug Provider.

7. Charges for that part of any Prescription Order exceeding 100 disposable insulin syringes or needles, 100 disposable blood/urine/glucose/acetone testing agents or 100 lancets or a 30 consecutive day supply. Charges for that part of any Prescription Order exceeding 300 disposable blood/urine/glucose/acetone testing agents or 300 lancets or a 90 consecutive day supply if the supplies are dispensed through a 90-Day Prescription Drug Provider.

8. Charges for drugs that are paid under another plan sponsor or payor as primary payor.

9. Charges for any Ancillary Charge.

10. Charges in excess of the Maximum Allowable Amount for any Prescription Drug.

11. Charges for Prescription Drugs or supplies requiring injectable parenteral administration or use, except insulin, unless authorized by the Plan under the Outpatient Prescription Drug Benefits section before they are dispensed.

12. Charges for any injectable Prescription Drugs or Specialty Pharmaceuticals, unless authorized by the Plan under this Outpatient Prescription Drug Benefits section before they are dispensed.

13. Any administrative charge for drug injections, or any administrative charges for any other drugs.

14. Except as described under a Prescription Order, charges for devices or supplies including, but not limited to:

    a. Blood/urine/glucose/acetone testing devices, needles, and syringes.
    b. Support garments.
    c. Bandages.
    d. Other non-medical items, regardless of intended use.

15. Charges for:

    a. Over-the-counter (OTC) medications that can be obtained without a Health Care Practitioner's Prescription Order, except injectable insulin.

b. Drugs that have an over-the-counter equivalent, or contain the same or therapeutically equivalent active ingredient(s) as over-the-counter medication, as determined by the Plan, unless specifically authorized for coverage by the Plan on the Drug List.

16. Charges for:

    a. Allergy sera.
    b. Allergy extract.

17. Charges for:

    a. Bulk powder/chemical drugs.
    b. Drugs containing, or made of, bulk powder/chemicals.
    c. Compounded Medications that contain one or more active ingredients that are not covered under this Plan.
    d. Combination drugs or drug products manufactured and/or packaged together and containing one or more active ingredients that are not covered under this Plan.
    e. Combination drugs or drug products that are manufactured and/or packaged together, unless authorized by the Plan under this Outpatient Prescription Drug Benefits section before they are dispensed.

18. Charges for:

    a. Prescription Order refills in excess of the number specified on the Health Care Practitioner's Prescription Order.
    b. Prescriptions refilled after one year from the Health Care Practitioner's original Prescription Order.
    c. Amounts above the Contracted Rate for Participating Pharmacy or Specialty Pharmacy Provider reimbursement.

19. Charges for:

    a. Drugs administered or dispensed by a Hospital, rest home, sanitarium, extended care facility, convalescent care facility, Subacute Rehabilitation Facility or similar institution.
    b. Drugs consumed, injected, or otherwise administered at the prescribing Health Care Practitioner’s office.
    c. Drugs that are dispensed at or by a Health Care Practitioner’s office, clinic, hospital, or other non-pharmacy setting for take home by the Covered Person.

20. Charges for:

    a. Any drug used for Cosmetic Services, as determined by the Plan.
    b. Drugs used to treat onychomycosis (nail fungus).
    c. Botulinum toxin and its derivatives.

21. Charges for drugs taken solely to prevent the transmission of disease during activities such as intercourse, sharing of needles, or direct or indirect exchange of bodily fluids.

22. Charges for: drugs prescribed for dental services; unit-dose drugs; or drugs used in the treatment of chronic fatigue or related syndromes or conditions.

23. Charges for DDAVP (desmopressin acetate) or other drugs used in the treatment of nocturnal enuresis (bedwetting) for a Covered Person under the age of 8.

24. Charges for: duplicate prescriptions; replacement of lost, stolen, destroyed, spilled or damaged prescriptions; prescriptions refilled more frequently than the prescribed dosage indicates.

25. Charges for drugs used to treat, impact or influence quality of life or lifestyle concerns including, but not limited to: athletic performance; body conditioning, strengthening, or energy; prevention or treatment of hair loss; prevention or treatment of excessive hair growth or abnormal hair patterns.

26. Charges for drugs used to treat, impact or influence: obesity; morbid obesity; weight management; sexual function, dysfunction or inadequacy; sexual energy, performance or desire; skin coloring or pigmentation; slowing the normal processes of aging; memory improvement or cognitive enhancement; daytime drowsiness; dry mouth; excessive salivation; or hyperhidrosis (excessive sweating).

27. Charges for drugs or drug categories that exceed any maximum benefit limit under this Plan.

28. Charges for Gene Therapy drugs for vision loss; or, drugs designed or used to diagnose, treat, alter, impact, or differentiate a Covered Person's genetic make-up or genetic predisposition, unless authorized by the Plan under this Outpatient Prescription Drug Benefits section before they are dispensed.

29. Charges for prescriptions, dosages or dosage forms used for the convenience of the Covered Person or the Covered Person's Immediate Family Member or Health Care Practitioner.

30. Charges incurred outside of the United States for drugs; charges for drugs obtained from pharmacy provider sources outside the United States, except for Covered Charges that are received for Emergency Treatment.

31. Charges for postage, handling and shipping charges for any drugs.

32. Charges for: Specialty Pharmaceuticals that are dispensed and/or distributed through a Pharmacy that is not a Participating Pharmacy or Specialty Pharmacy Provider; Specialty Pharmaceuticals not on the Drug List.

33. Charges for: vaccines and other immunizing agents, except as covered under the Clinical Preventive Services or Preventive Medicine Services provisions of the Medical Benefits section; biological sera; blood or blood products.

34. Charges for drugs for which prior authorization is required by the Plan and is not obtained.

35. Prescription Drugs previously classified with non-prescription status.

36. Charges for treatment, services, supplies or drugs provided by or through any employer of a Covered Person or the employer of a Covered Person’s family member. For purposes of this exclusion, "employer" includes but is not limited to any corporation, partnership, sole-proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer. "Employer" also includes any other affiliated providers in which there is common ownership between such providers and the “employer.”

37. Charges for treatment, services, supplies or drugs provided by or through any entity in which a Covered Person or their family member receives, or is entitled to receive, any direct or indirect financial benefit, including but not limited to an ownership interest in any such entity. For purposes of this exclusion, "entity" includes but is not limited to any corporation, organization, partnership, sole-proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.

X. COORDINATION OF BENEFITS (COB)

You or Your Covered Dependents may have coverage under more than one plan. If benefits are available through any other Medical Plan, We will take those benefits into account in calculating the amount of Covered Charges that may be payable by Us so that benefits from both Us and any other Medical Plan are limited to the actual charges Incurred.

If a Covered Person is entitled to benefits provided by another Medical Plan but does not claim them, We will consider the benefits to which a Covered Person is entitled as benefits that were provided. All claims should be submitted to Us and all other Medical Plans at the same time so that proper benefits can be determined and paid.

Coordination Of Benefits Definitions
For purposes of this section, in addition to any specific terms that are defined under the general Definitions section of this Plan, the following capitalized terms have the meanings given below:

1. **Allowable Charge:** Any charge which is a Covered Charge under this Plan and is, at least in part, covered under any other Medical Plan. If a Medical Plan provides benefits in the form of services rather than cash payments, We will determine a reasonable cash value for each service that is provided and that cash value will be considered the Allowable Charge and the amount paid by the other Medical Plan. The difference between an Acute Medical Facility's semi-private room rate and private room rate is not an Allowable Charge unless the private room is Medically Necessary. Benefit reductions due to failure to comply with Medical Plan provisions of the Primary Plan are not an Allowable Charge. If both the Primary Medical Plan and the Secondary Medical Plan have contractual discount arrangements, the Allowable Charge will be determined by applying the greater of the two discounts.

2. **Coordination of Benefits (COB):** Coordination of Benefits (COB) means that benefits are paid so that no more than 100% of the Allowable Charges for which the Covered Person is liable will be covered under the combined benefits received from all Medical Plans.

3. **Insured:** The person in whose name the Medical Plan is in force.

4. **Medical Plan:** Any Medical Plan which provides medical or dental benefits or services including, but not limited to:

    a. Group, blanket or franchise insurance that provides major medical benefits.
    b. Group-type insurance which can be obtained and maintained only as the result of membership in or connection with a specific group or organization.
    c. A service plan or contract, group or individual practice or other prepayment plan.
    d. Any employer or employee self-insurance plan.
    e. Coverage arranged by or through any trustee, union, employer or association.
    f. The medical or dental benefits coverage in group, group-type and individual automobile "no-fault" and traditional automobile "fault" type contracts (but only where permitted by law) or other medical or dental pay coverage.
    g. Health coverage, whether issued or administered on a group or individual basis.
    h. Group Blue Cross, group Blue Shield, group practice or prepaid group coverage.
    i. Coverage under trust or association plans or plans sponsored by unions, employer groups, or employee benefit groups.
    j. Medical coverage under automobile or no fault insurance, if coordination of benefits with such coverage is allowed by law.

5. **Primary Medical Plan:** A Medical Plan in which benefits must be determined without considering the benefits of any other Medical Plan. A Medical Plan is primary if:

    a. The Plan either has no rules for determining the order of benefits or has rules which differ from the rules in this Plan; or
    b. According to the Order of Benefit Determination provision, the Plan considers its benefits first.

6. **Secondary Medical Plan:** A Medical Plan in which benefits are determined after the benefits of the Primary Medical Plan have been determined.

How Benefits Are Paid
If We are the Primary Medical Plan, according to the Order of Benefit Determination provision in this section, We will pay benefits for Covered Charges that would have been paid under this Plan without regard to this COB section.

If We are the Secondary Medical Plan, according to the Order of Benefit Determination provision below, We will pay the lesser of:

1. The difference between the Allowable Charge and the amount paid by the Primary Medical Plan; or

2. Benefits for Covered Charges that would have been paid under this Plan without regard to this COB section.

When We are the Secondary Medical Plan, the benefits payable under this Plan will be reduced to the extent necessary so that when Our benefit payments are added to the benefits payable under all other Medical Plans, they do not exceed the total Allowable Charge for any services or equipment.

Order Of Benefit Determination
The Primary Medical Plan and Secondary Medical Plan are determined by using the following rules. Whichever rule below is the first to apply to the Covered Person's situation is the rule that will be used to determine which Medical Plan is the Primary Medical Plan and which is the Secondary Medical Plan.

1. A Medical Plan that does not have a COB provision, or has a provision that differs from this one, pays its benefits first.

2. A Medical Plan that covers the person as the Insured pays its benefits before a Medical Plan that covers the person as a dependent.

3. For a child whose parents are not divorced or separated:

    a. The Medical Plan of the parent whose birthday (month and day only) falls earlier in the Calendar Year pays its benefits first. It does not matter which parent is older.
    b. If both parents have the same birthday (month and day only), the Medical Plan covering the parent for the longer time period pays its benefits first.
    c. If one Medical Plan has this birthday rule and the other Medical Plan does not and, as a result, the Medical Plans do not agree on the order of benefits, the Medical Plan that does not have the birthday rule pays its benefits first.

4. For a child whose parents are separated or divorced:

a. If a court decree establishes which parent is responsible for the child's medical or dental expenses, the Medical Plan of that parent pays its benefits before any other Medical Plan that covers the child as a dependent. This applies only if the Medical Plan has actual knowledge of the terms of the court decree.

b. Otherwise, the Medical Plan of the parent with custody pays its benefits before the Medical Plan of the spouse of the parent with custody; and the Medical Plan of the spouse of the parent with custody pays its benefits before the Medical Plan of the parent without custody.

c. If a court decree establishes joint custody, without stating which one of the parents is responsible for the medical or dental expenses of the child, the Medical Plans covering the child will follow the rules in item 3 above.

5. A Medical Plan that covers the person as the Insured, who is neither laid off nor retired, or as a dependent of such an Insured pays its benefits before those of a Medical Plan covering the person as a laid off or retired Insured or as a dependent of such an Insured. However, if the other Medical Plan does not have this rule and, as a result, the Medical Plans do not agree on the order of benefits, this rule does not apply.

6. If a person is covered under a right of continuation pursuant to federal or state law and is also covered under another Medical Plan, the Medical Plan covering the person as the Insured or as a dependent of such an Insured pays its benefits before the Medical Plan providing the continued coverage.

7. If none of the above rules apply, the Medical Plan covering the person for the longer time pays its benefits first.

Rights Under This Section
We have the right to:

1. Release or obtain claim information from any Medical Plan, individual or entity.

2. Pay Our covered benefits to any Medical Plan or entity which has paid benefits that We should have paid.

3. Recover any overpayment made by the Plan from the person or entity to whom the payment was made.

We may obtain or release any information needed to carry out the intent of this section. You must inform the Plan if You or Your Covered Dependents have coverage under any other Medical Plans when the Covered Person makes a claim.

Medicare As Secondary Payor
Under federal law, Medicare is often the secondary payor for Coordination of Benefits purposes if an individual has other coverage in addition to Medicare.

The rules require coverage under other coverage before Medicare when:

1. You and/or Your covered Dependent spouse is age 65 or older and Your Employer employs at least 20 persons (including part-time Employees) for a minimum of 20 weeks during the current or preceding Calendar Year.

2. You and/or Your covered Dependent is under age 65 and is receiving Medicare benefits due to a disability and Your Employer has at least 100 people actively employed on 50 percent or more of the regular business days in the preceding Calendar Year.

3. A Covered Person is covered under an employer group health plan, is under age 65 and is eligible for Medicare due to end-stage renal disease. In this case, Medicare is usually secondary to coverage under the Plan for 30 months from the date of your Medicare eligibility.

This section regarding Medicare as a secondary payor may not apply to Your Employer. Please contact Your Employer to determine whether this section applies to the Plan.

XI. CLAIM PROVISIONS

Proof Of Loss
Most providers will file claims directly with the Plan. You are responsible for filing a claim with Us if the provider does not file it. The following provisions tell You how to file claims with the Plan.

We must receive written or electronic notice of the services that were received due to a Sickness or an Injury for which the claim is made. Notice must be provided to the Plan, via the Third Party Administrator identified in the Plan Administration Information section of the SPD, within 60 days after a covered loss occurs or as soon as reasonably possible. Proof of loss and sufficient information to process the claim must be received by the Plan within 180 days after the termination date of the Plan Year listed on Your Benefit Summary. Any claim denied for failure to file within the 6 months may be reconsidered if circumstances beyond the claimant's control resulted in a delayed filing by the provider.

The proof of loss must include all of the following:

1. Your name, identification number and group number.

2. The name of the Covered Person who Incurred the claim.

3. The name and address of the provider of the services.

4. An itemized bill from the provider of the services that includes all of the following as appropriate:

    a. International Classification of Diseases (ICD) diagnosis codes.
    b. International Classification of Diseases (ICD) procedures.
    c. Current Procedural Terminology (CPT) codes.
    d. Healthcare Common Procedure Coding System (HCPCS) level II codes.
    e. National Drug Codes (NDC).

5. A statement indicating whether the Covered Person has coverage for the services related to the Sickness or Injury under any other insurance plan or program. If the Covered Person has other coverage, include the name and identification number of the other coverage.

When the Plan receives written or electronic proof of loss, the Plan may require additional information. You must furnish all items the Plan decides are necessary to determine the Plan's liability in accordance with the Right to Collect Information provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to the Plan.

Right To Collect Information
To determine the Plan's liability, the Plan may request additional information from a Covered Person, Health Care Practitioner, facility, or other individual or entity. A Covered Person must cooperate, and assist the Plan by obtaining the following information within 45 days of Our request. Charges will be denied if the Plan is unable to determine liability because a Covered Person, Health Care Practitioner, facility, or other individual or entity failed to:

1. Authorize the release of all medical records to the Plan and other information as requested.

2. Provide the Plan with information requested about pending claims, other insurance coverage or proof of Creditable Coverage.

3. Provide the Plan with information as required by any contract with the Plan or a network including, but not limited to, repricing information.

4. Provide the Plan with information that is accurate and complete.

5. Have any examination completed as requested by the Plan.

6. Provide reasonable cooperation to any requests made by the Plan.

Such charges may be considered for benefits upon receipt of the requested information, provided all necessary information is received prior to expiration of the time allowed for submission of claim information as set forth in this Claims Provisions section.

Physical Examination
We have the right to have a Health Care Practitioner of Our choice examine a Covered Person at any time regarding a claim for benefits or when authorization is requested under the Utilization Review Provisions section. These exams will be paid by Us. We also have the right, in case of death, to have an autopsy done where it is not prohibited by law.

Payment Of Benefits
When We receive due written proof of loss, We pay Participating Providers directly for Covered Charges.

If proof of loss is received from a Health Care Practitioner, facility, supplier, or provider that does not have a Contracted Rate or Negotiated Rate, benefits will be payable to You, unless You have assigned benefits in accordance with the Assignment of Benefits provision.

Any benefits unpaid at Your death will be paid at Our option to Your spouse, Your estate, or the providers of the services.

We will pay medical claims when coded according to the latest editions of the Current Procedural Terminology (CPT) manual or International Classification of Diseases (ICD) manual. We will not pay for: charges that are billed separately as professional services when the procedure requires only a technical component; or charges that are billed incorrectly or billed separately but are an integral part of another billed service, as determined by Us; or other claims that are improperly billed; or duplicates of previously received or processed claims.

Submitted charges may be applied to the Covered Person's Deductible without review. Application of the charges to the Deductible does not guarantee future coverage of similar expenses. We reserve the right to review any and all claims for eligibility for coverage at the time each claim is submitted. You may request a review while claims are being applied to the Deductible by calling or writing to the Plan.

Any amount We pay in good faith will release Us from further liability for that amount. Payment by Us does not constitute any assumption of liability for coverage of a Sickness or an Injury. It also does not constitute any assumption of liability for further coverage. Any benefit paid in error may be recovered from You or the person or entity receiving the incorrect payment. We may offset the overpayment against future benefit payments.

Assignment Of Benefits
With respect to a Health Care Practitioner, facility, supplier, or provider that does not have a Contracted Rate or Negotiated Rate, benefits for Covered Charges under this Plan may be assigned by a Covered Person to the provider as consideration in full for services rendered.

The Plan is not responsible for determining whether any such assignment of benefits is valid.

Payment of benefits which have been assigned may be made directly to the assignee, unless the Covered Person submits a written request not to honor the assignment, and such request is received by the Plan before the proof of loss is submitted.

If benefits are not assigned to the provider, and such benefits are paid directly to the Covered Person, the Plan is deemed to have fulfilled its obligations with respect to such benefits.

A Health Care Practitioner, facility, supplier, or provider which accepts an Assignment of Benefits in accordance with this Plan may not, at any time, assign its right to:

1. Pursue legal action to recover benefits under the Plan;

2. Enforce rights due under the Plan; or,

3. Pursue any other causes of action which he/she may have against the Plan or its fiduciaries.

A Health Care Practitioner, facility, supplier, or provider which accepts an Assignment of Benefits in accordance with this Plan is bound by the Plan's terms, limits, and conditions ("Plan parameters").

Benefits Not Transferable
Only the Covered Person is entitled to receive benefits under this Plan, except as otherwise stated.

A Covered Person may not, at any time, consent to assign his/her right to:

1. Pursue legal action to recover benefits under the Plan;

2. Enforce rights due under the Plan; or,

3. Pursue any other causes of action which he/she may have against the Plan or its fiduciaries.

The Covered Person may not assign his/her rights at any time, either during the time in which he/she is covered under the Plan, or following his/her termination as a Covered Person.

Timely Redemption of Payment
To the extent any claims payment check remains uncashed after 12 months from the date the check was issued, or if a payment issued by other means is unredeemed after 12 months from the date the payment was issued, the claim shall be deemed denied upon the expiration of such 12 month period. To the extent the claim is denied in accordance herewith, and You or the provider to whom You assigned benefits submit a timely appeal of that denial (in accordance with the appeal procedures set forth in this SPD), the claim may be reconsidered.

Rights Of Administration
The Plan maintains Our ability to determine Our rights and obligations under this Plan including, without limitation, the eligibility for and amount of any benefits payable.

Claims Involving Fraud Or Misrepresentation
Claims will be denied in whole or in part in the event of misrepresentation or fraud by a Covered Person or a Covered Person's representative. If benefits are paid under this Plan and it is later shown the claims

for these benefits involved fraud or misrepresentation, the Plan will be entitled to a refund from You, the Beneficiary or the person receiving the payment.

A claim will not be honored if the Covered Person or the provider of the charges will not, or cannot, provide adequate documentation to substantiate that treatment was rendered for the claim submitted. If the Covered Person, or anyone acting on the Covered Person's behalf, knowingly file a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Covered Person may be subject to civil and/or criminal penalties.

Claims Provisions Definitions
For purposes of this section, in addition to any specific terms that are defined under the general Definitions section of this Plan, the following capitalized terms have the meanings given below:

1. **Claim Involving Urgent Care:** Any claim for medical care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations (a) could seriously jeopardize Your life or health or Your ability to regain maximum function or (2) in the opinion of a Health Care Practitioner who has knowledge of Your medical condition, which subjects You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

2. **Pre-Service Claim:** Any claim for a benefit with respect to which the terms of the SPD condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

3. **Post-Service Claim:** Any claim for a benefit that is not a Pre-Service Claim.

4. **Adverse Benefit Determination:** Any denial of a benefit, reduction of a benefit, termination of a benefit, or failure to pay (in whole or in part) for a benefit. This term includes any benefit denial, benefit reduction, benefit termination, or failure to pay, that:

    a. Is based upon a determination of a participant's or beneficiary's eligibility to participate in the Plan;
    b. Results from the usage of any Utilization Review Process; or
    c. Fails to cover an item or service for which benefits are otherwise provided based upon a determination that the item or services is an Experimental Or Investigational service or is not Medically Necessary or appropriate.

Timing Of Notification Of Benefit Determination
Urgent Care Claims
In the case of a Claim Involving Urgent Care, the Plan will notify You or Your authorized representative of the benefit determination as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim by the Plan.

If You or Your authorized representative do not provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan will notify You or Your authorized representative as soon as possible, but no later than 24 hours after receipt of the claim by the Plan. The notice will describe the specific information necessary to complete the claim. In such a case, You will be allowed a reasonable amount of time, not less than 48 hours, to provide the specified information. The Plan will notify You or Your authorized representative of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of: (1) the Plan's receipt of the specified information; or, (2) the end of the period afforded You or Your authorized representative to provide the specified additional information.

Pre-Service Claims
In the case of a Pre-Service Claim, the Plan will notify You or Your authorized representative of the benefit determination within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan.

The Plan may extend the period of review once, for up to 15 days, in a case where the Plan determines that extension is needed due to matters beyond its control. If it is determined that an extension is needed, prior to the expiration of the initial 15 day period the Plan must notify You or Your authorized representative of the reasons for extension and of the new determination date.

Post-Service Claims
In the case of a Post-Service Claim, the Plan will notify You or Your authorized representative of the benefit determination within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt of the claim by the Plan.

The Plan may extend the period of review once, for up to 15 days, in a case where the Plan determines that extension is needed due to matters beyond its control. If it is determined that an extension is needed, prior to the expiration of the initial 30 day period the Plan must notify You or Your authorized representative of the reasons for extension and of the new determination date.

Manner And Content Of Notification Of Adverse Benefit Determination
The notification of any Adverse Benefit Determination will be provided to You or Your authorized representative, and include the following information:

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

2. The specific SPD provisions on which the Adverse Benefit Determination is based.

3. Any additional material or information necessary for You or Your authorized representative to perfect the claim, and an explanation of why such material or information is necessary.

4. The Plan's review procedures, and the time limits applicable to such procedures, including a statement of Your right to bring a civil action under section 502(a) of ERISA following an appeal.

5. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, You will be furnished with either: (a) a copy of the specific rule, guideline, protocol or other criterion; or (b) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, and that a copy will be provided to You free of charge upon request.

6. If the Adverse Benefit Determination is based upon Medical Necessity or experimental treatment, or similar exclusion or limit, You will be furnished with either: (a) an explanation of the scientific or clinical judgment for the Adverse Benefit Determination, applying the terms of the SPD to Your medical circumstances; or, (2) a statement that such explanation will be provided to You free of charge upon request.

7. In the case of an Adverse Benefit Determination concerning a Claim Involving Urgent Care, You will be furnished with a description of the applicable expedited review process.

Procedures To Appeal An Adverse Benefit Determination

1. Your or Your authorized representative has 180 days following receipt of an Adverse Benefit Determination within which to appeal the determination. You or Your authorized representative must submit a written request for an appeal to the Third Party Administrator identified in the Plan Administration Information section of the SPD.

2. You or Your authorized representative will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits.

3. You or Your authorized representative will be provided reasonable access to, and copies of, all documents, records and other information relevant to Your claim for benefits free of charge upon request.

4. All comments, documents, records and other information submitted by You or Your authorized representative relating to the claim will be reviewed without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

5. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual. The named fiduciary will conduct a completely new review, not taking into account the initial determination.

6. In deciding an appeal that is based (in whole or in part) on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not Medically Necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional engaged for purposes of consultation will not be the same person who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, or that person's subordinate.

7. Upon request, You or Your authorized representative will be provided the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination.

8. With respect to a Claim Involving Urgent Care, an expedited review process will be provided for which: (1) a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally, or in writing, by You or Your authorized representative; and (2) all necessary information, including the Plan's benefit determination review, will be transmitted between the Plan and You or Your authorized representative by telephone, facsimile, or other similarly expeditious method that is available.

Manner And Content Of Notification Of Appeal Decision
The notification of any decision concerning an appeal of an Adverse Benefit Determination will be provided to You or Your authorized representative and include the following information:

1. The specific reason or reasons for the appeal decision.

2. Reference to the specific SPD provisions on which the appeal decision is based.

3. A statement that upon request, You or Your authorized representative will be provided reasonable access to and copies of all documents, records and other information relevant to Your claim for benefits free of charge.

4. A statement describing any voluntary external review procedures and Your right to obtain information about such procedures, and Your right to bring a civil action under section 502(a) of ERISA.

5. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the appeal decision concerning an Adverse Benefit Determination, You or Your authorized representative will be provided with either: (a) the specific rule, guideline, protocol or other similar criterion that was relied upon in making the appeal decision concerning the Adverse Determination; or, (b) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the appeal decision concerning the Adverse Determination, and that a copy will be provided to You free of charge upon request.

6. If the appeal decision concerning the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, You or Your authorized representative will be provided with either: (a) an explanation of the scientific or clinical judgment for the decision, applying the terms of the SPD to Your medical circumstances; or, (b) a statement that such explanation will be provided to You free of charge upon request.

Timing Of Notification Of Appeal Decision
After an Adverse Benefit Determination is reviewed, You or Your authorized representative will receive notice of the appeal decision.

For an appeal of an Adverse Benefit Determination concerning a Claim Involving Urgent Care, You or Your authorized representative will receive the appeal decision within 72 hours of the Plan's receipt of Your request for appeal.

For an appeal of an Adverse Benefit Determination concerning a Pre-Service Claim, You or Your authorized representative will receive the appeal decision within 30 days of the Plan's receipt of Your request for appeal.

For an appeal of an Adverse Benefit Determination concerning a Post-Service Claim, You or Your authorized representative will receive the appeal decision within 30 days of the Plan's receipt of Your request for appeal.

Concurrent Care Decisions
If You are undergoing a course of treatment and We notify You that we intend to reduce or terminate the benefits for that course of treatment before the end of the period of time or number of treatments that were previously approved, You have the right to appeal. We must give You enough advance notice to allow you to appeal before the termination or reduction takes effect.

If Your appeal concerns a Claim Involving Urgent Care, We will make a decision on Your appeal within 24 hours, provided You asked for the appeal at least 24 hours prior to the end of the originally approved course of treatment.

Appeal Rights
You may appeal any coverage or claim determination made by Us to deny, reduce, or terminate the provision or payment for health care services under Your Plan. The Covered Person must submit a written request for an appeal to the Third Party Administrator identified in the Plan Administration Information section of the SPD. Appeals must be submitted in accordance with Our appeal policy and required timeframes, as set forth in Your SPD. The internal appeals process includes 2 levels of appeal.

When we have made an Adverse Benefit Determination based on a judgment as to Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service, and you have exhausted the internal appeal process (except for urgent appeal requests), You have the right to have Our decision reviewed by an independent review organization external to Us. A request for an external independent review must be submitted within 4 months from the date You received notice of the Adverse Benefit Determination through Our internal appeal process.

Except when a Covered Person's life or health would be seriously jeopardized, You must first exhaust Our internal appeal process before we will grant Your request for an external independent review.

XII. SUBROGATION, REIMBURSEMENT AND THIRD-PARTY RECOVERY PROVISIONS

Payment Condition

The purpose of the Plan is to pay covered expenses if they are not paid or payable by any other person or entity, in accordance with the terms of the Plan. If a Covered Person is injured, disabled or becomes ill as a result of the actions of a Third Party, the costs associated with the injury, illness or disability should be paid or payable by Third-Party Coverage, including coverage belonging to the Covered Person designed to compensate the Covered Person for the acts of Third Parties, such as uninsured or underinsured motorist coverage. If a Covered Person is injured, disabled or becomes ill and a Third Party is or may be responsible for such illness or injury, the Plan may conditionally advance payment of Benefits for such injury, illness or disability provided that the requirements of this Section are satisfied.

By accepting Benefits under the Plan, the Covered Person(s), their attorneys, representatives, and/or legal guardian of a minor or incapacitated individual is subject to the terms and conditions of this Section regarding Subrogation, Reimbursement, and Third-Party Recovery. In the event a Covered Person settles, recovers, or is reimbursed by any Third Party or Third-Party Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. Moreover, by accepting benefits the Covered Person(s), their attorney, representatives, and/or legal guardian of a minor or incapacitated individual agrees that the Plan shall have an equitable lien on the entire amount of any and all funds received by the Covered Person from any Third Party or Third-Party Coverage up to the Reimbursement Amount, which shall be maintained in trust for the benefit of the Plan until the obligations under this Section are fully satisfied. The Plan shall also be designated as co-payee on any and all settlement drafts.

In addition, the Plan maintains a right of Subrogation, meaning the right of the Plan to be substituted in place of the person who received Benefits with respect to any lawful claim, demand, or right of action against any Third Party who may be liable for the injury, illness or disability that resulted in payment of Plan Benefits. The Third Party may not be the actual person who caused the injury, and may include an insurer.

The Plan Administrator has discretion to interpret and apply the terms of this Section.

Subrogation, Reimbursement and Third-Party Recovery Definitions
For purposes of this section, in addition to any specific terms that are defined under the Definitions Glossary section of this Plan, the following capitalized terms have the meanings given below:

> **Benefits**. All Plan payments and future payments related to an injury, illness or disability.
>
> **Covered Person.** A person who is eligible to receive Benefits under this Plan and for whom coverage is in effect based on enrollment approved by the Plan. The obligations of this Section applies to the Covered Person's attorneys, representatives, and/or legal guardians of a minor or incapacitated individual.
>
> **Recovery.** Any and all payments or future payments from another source or Third-Party Coverage to which the Covered Person is entitled (including, but not limited to, any amounts allocated to a trust set up by the Covered Person or on the Covered Person's behalf) as a result of the Covered Person's injury, illness or disability, including any judgment, award, or settlement regardless of how the recovery is termed, allocated, or apportioned and regardless of whether any amount is specifically included or excluded as medical expenses including but not limited to recovery designated as pain and suffering, noneconomic damages, and/or general damages.

The Plan's right of recovery extends to any amount paid by the Plan that is in any way related to the injuries incurred, whether paid directly or indirectly to the Covered Person, the Covered Person's spouse, dependents, beneficiaries, estate, trustees, guardians, personal representatives, other representatives or attorneys, and whether held in trust or constructive trust for the benefit of any of those parties.

Subrogation. Subrogation is the Recovery, from a Third Party or Third-Party Coverage, of medical costs and other Benefits that were originally paid by the Plan to or on behalf of the Covered Person.

Third Party. The term "Third Party" is defined as any party or entity besides the Plan or the Covered Person. A Third Party includes but is not limited to any insurer who provides coverage to the Covered Person or the Plan Sponsor or any entity in the Plan Sponsor's corporate structure. Third Party is intended to be construed as broadly as possible.

Third-Party Coverage. Third-Party Coverage means any payment source besides the Plan or the Covered Person and includes but is not limited to: a self-insured person, corporation, association, governmental entity, crime victim's restitution fund, insurance coverage, including liability insurance, uninsured/underinsured motorist (UM/UIM), personal umbrella coverage, no-fault coverage such as personal injury protection (PIP) or medical payments (MedPay) insurance, school or athletic policies, boat coverage, medical payments coverage from any source or workers' compensation or similar occupational coverage, or a settlement or trust fund established for the purpose of paying past or future medical expenses.

Exclusions

Benefits are not available under this Plan when coverage is available through any Third-Party Coverage, including but not limited to:

1. Motor vehicle medical or motor vehicle no-fault
2. Personal injury protection (PIP) coverage
3. Boat coverage
4. Liability coverage
5. Homeowner policy
6. School or athletic policy
7. Other types of liability insurance
8. Uninsured or Underinsured motorist coverage
9. Any excess insurance coverage
10. Workers' compensation or similar occupational coverage
11. Occupational coverage required of, or voluntarily obtained by, the employer
12. State or Federal workers' compensation acts
13. Any legislative act providing compensation for work-related illness or injury

These exclusions apply whether or not the Covered Person actually applies for these benefits. It is the Covered Person's responsibility to pursue all other available coverage to the fullest extent permitted by law before seeking benefits under the Plan. If the Covered Person pursues such coverage, and the coverage is denied, the Plan reserves the right to conditionally advance benefits while the Plan and/or the Covered Person seek to overturn the denial.

The Covered Person is responsible for any cost-sharing required by any of the above-referenced coverages. When the Covered Person is making elections for coverages required by state law, such as

automobile no-fault policies, the Covered Person may not elect such coverage as secondary, or purchase less than otherwise required coverage in an effort to shift liability to the Plan for coverage. If the Covered Person elects less than otherwise mandated coverage, the Plan will not provide coverage for the difference between the elected coverage and the otherwise mandated coverage.

If other insurance is available for medical benefits, the Covered Person will be deemed to have put the benefit to use towards medical bills if it was paid out for before coverage under the Plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, Benefits will be provided according to the Plan.

Subrogation

Subrogation is the process by the Plan seeks to recover directly from a Third Party or Third-Party Coverage for Benefits paid or payable by the Plan. As a condition of receiving Benefits under the Plan, the Covered Person, agrees to assign to the Plan the right to pursue a claim against any Third Party or Third-Party Coverage.

The Plan may, at its discretion, in its own name or in the name of the Covered Person, their personal representative or legal guardians, commence a proceeding or pursue a claim against any Third Party or Third-Party Coverage for the recovery of all damages to the full extent of all Benefits paid or payable. The Plan shall have the right to join or intervene in any suit or claim against a Third Party brought by Covered Person. The Covered Person shall fully cooperate with the Plan in the prosecution of any such claims. The Covered Person shall do nothing to prejudice the Plan's rights to pursue such coverage.

Reimbursement and Equitable Lien By Agreement

The Plan shall be entitled to recover, in first priority, 100% of the benefits paid out of the entire amount of any settlement, judgment, or any recovery from a Third Party or Third-Party Coverage, without deduction for a Covered Person's attorneys' fees, expenses, or application of the common fund doctrine, make whole doctrine, or any other common law doctrine or state statute that purports to restrict the Plan's right to reimbursement. The Plan shall have a first-priority equitable lien by agreement which supersedes all State common law or statutory rules and doctrines that purport to limit or restrict the Plan's equitable lien and right to reimbursement. The Plan's rights shall apply, in full, to any recovery made by a Covered Person that is in any way related to the injury or event giving rise to the payment of Plan benefits. Neither any classification of the settlement or judgment, nor limitations on the types of damages a Covered Person may or has elected to pursue, shall limit the Plan's rights.

The Plan shall not be responsible for nor shall its equitable lien and right to reimbursement be reduced for the Covered Person's court costs, experts' fees, attorneys' fees, filing fees or other costs or expenses of litigation without prior, expressed written consent from the Plan. Furthermore, the Plan's interest takes priority over any and all other claims to the settlement funds, including but not limited to any claim or lien for attorney's fees. The Covered Person is solely responsible for their fee arrangement with their attorney, and such an arrangement shall not diminish the Plan's rights. The Covered Person agrees to defend and indemnify the Plan from any such claims brought by the Covered Person's attorneys or other representatives.

The Plan's equitable lien and right to reimbursement shall not be reduced or affected as a result of any comparative or contributory negligence attributed to the Covered Person. Any state lien reduction statutes purporting to reduce the Plan's equitable lien and right to reimbursement are preempted by federal law and the terms of this Plan and will not reduce the Plan's reimbursement rights. The Plan's

equitable lien and right to reimbursement is not dependent upon whether the Covered Person was fully-compensated by the settlement, judgment or recovery from a Third Party or Third-Party Coverage.

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exists separately from the property and estate of the Covered Person, such that the death or incapacitation of the Covered Person, or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien and the Plan's right to reimbursement. The Plan's equitable lien is recoverable even if the Covered Person's settlement, judgment or recovery from a Third Party or Third-Party Coverage has been commingled with other assets or accounts.

If the Covered Person dies as a result of the injury, illness or disability and a wrongful death or survival claim is asserted against a Third Party or Third-Party Coverage, the Plan's rights of subrogation and reimbursement shall still apply, and the individual, entity or personal representative pursuing such a claim shall be bound by the Plan terms, including the obligation to reimburse the Plan from any such recovery. The Plan's rights shall fully apply to all Covered Persons, including minors.

Covered Person's Reimbursement and Subrogation Responsibilities

The Plan shall deny or delay claims related to an injury or illness that may be caused by a Third Party, or it may recoup the costs of claims already paid for such injury or illness, or offset any related and non-related incoming claims for benefits if any of the following requirements are not satisfied:

1. The Covered Person shall notify the Plan of the existence of the injury or illness for which a Third Party may be responsible immediately and no later than 30 days of any claim that may give rise to the Plan's claim for Subrogation or Reimbursement.

2. The Covered Person or their legal representative must, as soon as practical but in no event later than within 14 business days of receiving a request from the Plan, provide all information and sign and return all documents necessary to exercise the Plan's reimbursement rights under this Section. This obligation extends to settlement agreements with any Third Party, regardless of whether such agreements purport to be confidential. The Covered Person shall not, and their legal representative shall ensure that they do not, enter into any confidentiality agreement that would purport to limit the Plan's right of access to information related to the injury or event, and settlement or judgment related thereto, which gives rise to the payment of Plan benefits.

3. The Covered Person shall comply with all of the Plan's claim and records procedures and cooperate fully with the Plan in the recovery of the Benefits advanced by the Plan and the Plan's exercise of its reimbursement and subrogation rights. The Covered Person shall not take any action which would result in the reduction of available Third-Party Coverage.

4. The Covered Person shall complete and submit to the Plan an Incident Claim Form, an acknowledgement of the Plan's rights as outlined in this section if requested, and any other documents required by the Plan. If requested by the Plan pursuant to its Plan Administrator's discretionary authority, a Subrogation and Reimbursement acknowledgement shall be reviewed, signed and returned to the Plan by the Covered Person and the Covered Person's attorney if one is retained. It is the Covered Person's responsibility to notify the Plan or its representatives immediately upon retention of an attorney, who must also, if requested, acknowledge the Plan's terms. The Covered Person's failure to sign such an agreement will have no impact on the Plan's rights

5. The Covered Person shall provide all information about the Covered Person's illness or injury as requested by the Plan.

6. The Covered Person shall keep the Plan advised of any changes in the status of the Covered Person's suit and/or claim against the Third Party or Third-Party Coverage.

7. The Covered Person shall refrain from doing anything to impair, prejudice or compromise the Plan's subrogation and reimbursement rights without prior written agreement by the Plan's Administrator.

8. The Covered Person shall notify, and instruct their agents or attorneys to notify the Plan at least 14 days prior to any settlement or any trial or other material hearing concerning the suit or claim is held. If a mediation, settlement conference, or arbitration is scheduled, the Covered Person or their legal representative shall provide the Plan with notice of such an event within 1 business day of its scheduling, and shall provide the Plan with an opportunity to participate, and copies of all submissions made by the Covered Person, the Third Party, or any other interested party, to the neutral handling the event.

9. The Covered Person shall be solely responsible for their attorney's fees and expenses incurred in pursuing a Third Party or Third-Party Coverage. The Plan shall not be liable for any costs or attorney's fees incurred by the Covered Person in pursuing the Covered Person's suit or claim, regardless of any common fund, make whole, or any other common law doctrine or state statute that requires the Plan to pay a portion of the Reimbursement Amount to the Covered person or their attorney for the legal fees or legal expenses incurred in the collection of the Recovery. The Covered Person shall defend, indemnify and hold harmless the Plan from any claims by the Covered Person's attorney against the Plan seeking attorney's fees or costs. The Plan's interest shall take priority over any claim the Covered Person's attorney may have on any settlement fund or judgment.

Reimbursement and Subrogation Procedures

The Covered Person shall be responsible for compliance by their agents and attorneys with the procedures set forth in this Section. If the Covered Person receives a Recovery, the Covered Person or their attorney shall hold the Recovery funds separately from other assets until the Plan's reimbursement rights have been satisfied. The Covered Person shall require that their attorney hold any settlement funds in trust, and not issue any disbursement, including to the Covered Person, until the Plan has, in writing, acknowledged that its interest in the settlement funds has been fully satisfied, or otherwise agrees, in writing, to permit some or all funds to be disbursed to an entity other than the Plan.

The Plan shall hold a claim, equitable lien, and constructive trust over any and all Recovery funds and those funds shall remain segregated and under the Covered Person's or Covered Person's agent's control. Once the Plan's reimbursement rights have been determined, the Covered Person shall make immediate payment to the Plan out of the Recovery proceeds. Alternatively, or in addition, the Plan Administrator, in exercising its discretionary authority shall be entitled to assert a suit or claim in the Covered Person's name or on the Covered Person's behalf in the Plan's name and the Covered Person shall cooperate with the Plan's prosecution of any such suit or claim. In exercising its rights under this Section, the Plan may consider, among other things, the sources of Recovery from any Responsible Third Party or Parties, any claims and defenses in any action or potential action, the strength or weakness of any claims or defenses, and litigation risk.

Noncompliance

If the Covered Person receives a Recovery but does not promptly segregate the Recovery funds and reimburse the Plan in first-priority as required in this Section from those funds, the Plan shall be entitled to take action to recover its equitable lien. Such action shall include, but shall not be limited to:

1. Initiating an action against the Covered Person and/or the Covered Person's attorneys to compel compliance with this Section. If the Plan must initiate legal action against the Covered Person and/or their attorney, the Covered Person and their attorney and law firm shall be jointly and severally liable for the Plan's legal fees and costs associated with their recovery efforts;

2. Withholding or suspending all benefits payable to or on behalf of the Covered Person, and all eligible Covered Persons receiving benefits under the same policy (i.e. the Covered Person's family members) until the Covered Person complies or until the equitable lien has been reimbursed to the Plan; or

3. Recouping previously-paid accident-related benefits from providers;

4. Initiating other appropriate actions.

If the Covered Person does not reimburse the Plan within sixty (60) days of receiving the Recovery, the Covered Person shall be responsible for paying the Plan one (1%) percent interest per month on the lien amount until the Plan receives reimbursement in full.

Offset and Conclusion of Claim

Once a Covered Person has settled or received a settlement, judgment or award or any type of recovery from a Third Party or Third-Party Coverage, (1) the Covered Person shall hold any funds in trust until the Plan's rights and interests in such recovery have been resolved and satisfied and (2) no further medical expenses associated with that injury, illness or disability be paid by the Plan unless the Plan Administrator in its discretion agrees in writing that future medical expenses related to injury, illness or disability will be covered.

XIII. CONTINUATION

If You or any Covered Dependents are no longer eligible for coverage under this Plan, coverage may be continued. Your Plan will inform You of the right of continuation.

Federal Continuation Rights
Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as enacted, and later amended contains federal requirements for coverage.

COBRA federal legislation applies to any employer, except the federal government and religious organizations, which:

1. Maintains a group health plan; and

2. Employed 20 or more full-time equivalent employees on more that 50% of its typical business days during the preceding Calendar Year.

Under this section, "Qualified Beneficiary" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Plan as: (a) an active, Covered Employee; or (b) the spouse or dependent of an active, Covered Employee. A Child born to, or placed for adoption with, the Covered Employee during a continuation period is also a Qualified Beneficiary.

If Group Health Benefits End
In general, if group health benefits for a Qualified Beneficiary end due to termination of employment or reduction of work hours, the Qualified Beneficiary may elect to continue such benefits for up to 18 months, unless employment is terminated due to gross misconduct.

Disabled Qualified Beneficiaries
In general, if a Qualified Beneficiary is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to termination of employment or reduction of work hours, the Qualified Beneficiary and/or any family member who is a Qualified Beneficiary may elect to extend the 18 month continuation period explained above for up to an additional 11 months.

To elect the 11 month extension of continuation, a Qualified Beneficiary must give the Employer written proof of the Social Security's determination of the disability before the earlier of: (a) the end of the initial 18 month continuation period; or (b) 60 days after the date the Qualified Beneficiary is determined to be disabled. If, during the 11 month extended continuation period, the Qualified Beneficiary is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end.

Death While Covered
If the Covered Employee dies while covered, any Qualified Beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last up to 36 months.

Divorce Or Legal Separation
Upon legal divorce or legal separation, any Qualified Beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last up to 36 months.

If A Covered Dependent Loses Eligibility

In general, if a Dependent child's group health benefits end due to his or her loss of Dependent eligibility as defined in this SPD, he or she may elect to continue such benefits. However, such Dependent child must be a Qualified Beneficiary. The continuation can last up to 36 months.

Concurrent Continuations
If a covered spouse or other Dependent elects to continue his or her group health benefits due to a Covered Employee's termination of employment or reduction of work hours, the spouse and/or Dependents may elect to extend their 18 month or 29 month continuation period to up to 36 months, if during the 18 month or 29 month continuation period, either: (a) the spouse or Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or (b) the Covered Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will run concurrently.

Special Medicare Rule
If a Covered Employee becomes entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a covered spouse or Dependent. The continuation period for such covered Dependents, after such termination of employment or reduction of work hours, will be the longer of: (a) 18 months (or 29 months if the Disabled Qualified Beneficiaries provision applies) from such termination of employment or reduction of work hours; or (b) 36 months from the date of the Qualified Beneficiary's entitlement to Medicare.

Notice Requirement
A person eligible for continuation under this section must notify the Employer, in writing, of: (a) a legal divorce or legal separation; or (b) the loss of a Child's Dependent eligibility, as defined in this SPD.

Such notice must be given to the Employer within 60 days of the later of: (a) the date of the event; or, (b) the date the Qualified Beneficiary would lose coverage.

Employer's Responsibilities
The Employer must notify the Qualified Beneficiary, in writing, of: (a) his or her right to continue this Plan's group health benefits; (b) the monthly contribution he or she must pay to continue such benefits; and (c) the time and manner in which such monthly payments must be made.

Such written notice must be given to the Qualified Beneficiary within 44 days of: (a) the Covered Employee's death, Medicare eligibility, termination of employment or reduction of work hours; or (b) 14 days of the date the Employer receives notice, in writing, of the legal divorce or legal separation, or the loss of Dependent eligibility of a Covered Dependent child.

Election Of Continuation Rights
To continue his or her group health benefits, the Qualified Beneficiary must give the Employer written notice that he or she elects to continue. A child's parent or legal guardian may elect continuation coverage on behalf of the child. The election must be made within: (a) 60 days of the date coverage would otherwise end if the election is not made; or, (b) if later, 60 days from the date the termination of coverage notice is issued by the Employer as described above.

The payments must be paid by the Qualified Beneficiary to the Employer, in advance, at the times and in the manner specified by the Employer.

The monthly payment will be a reasonable estimate of the cost of providing the group health benefits had the Qualified Beneficiary stayed covered under the Plan on a regular basis. It includes any amount that would have been paid by the Employer. In general, an additional charge of two percent (2%) of the total monthly charge also may be required by the Employer.

If the Qualified Beneficiary fails to give the Employer notice of his or her intent to continue, or fails to pay any required monthly payment in a timely manner, he or she waives continuation rights.

Continuation Grace Period
A Qualified Beneficiary's contribution payment is timely if, with respect to the first payment after the Qualified Beneficiary elects to continue, such payment is made no later than 45 days after such election. In all other cases, contribution payment is timely if it is made within 31 days of the specified due date.

When Continuation Ends
A Qualified Beneficiary's continued group health benefits end on the first of the following:

1. With respect to continuation upon termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

2. With respect to a disabled Qualified Beneficiary who has elected an additional 11 months of continuation, the earlier of: (1) the end of the 29 month period, which starts on the date the group health benefits would have otherwise ended; or (2) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled Qualified Beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act;

3. With respect to continuation upon death, a legal divorce or legal separation, or the end of a Covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would have otherwise ended;

4. With respect to a Covered Dependent whose continuation is extended due to the Special Medicare Rule provision, the end of the continuation period specified in that provision;

5. The date the Employer ceases to provide any group health plan to any Employee;

6. The end of the period for which the last monthly bill payment is made;

7. The date the Qualified Beneficiary first becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or

8. The date the Qualified Beneficiary first becomes entitled to Medicare.

Address Change
If COBRA continuation coverage is elected, qualified beneficiaries must notify the Plan or the Plan Administrator of any address changes.

Right to Elect Individual Coverage
There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Special Continuation Rights For Active Duty Military Personnel Under The Uniformed Services Employment And Re-Employment Rights Act ("USERRA")

Under this provision, an "Eligible Person" means any person who at the time the Covered Employee leaves employment for active military duty, training, inspection for duty, or honorary military funeral duty ("active duty"), is covered for group health benefits under this Plan and is either: (a) an Employee who leaves employment for active duty; or (b) the spouse or Dependent child of the Covered Employee who is leaving for active duty and who is covered by the Plan as of the date the Covered Employee leaves employment for active duty.

Group Health Benefits End

An Eligible Person may elect to continue his group health benefits for up to 24 months after the date on which such benefits would otherwise end because the Covered Employee leaves employment for active duty.

During the 24 month period, in the case of the death of the Covered Employee, a divorce from the Covered Employee, or a Dependent child otherwise becomes ineligible for coverage under the Plan, the spouse or Dependent child may continue their coverage until the end of the original 24 month period with the payment of the appropriate monthly payment. No additional months of coverage will be added to the original 24 month period due to such an event.

Additionally, coverage under this USERRA provision will run concurrently with, and be instead of, continuation coverage that would otherwise be available under COBRA.

Eligible Person's Responsibilities

The Eligible Person must elect to continue group health benefits in writing and pay the first month's payment to the Employer no later than 31 days from date his or her group health benefits would otherwise end.

If the Eligible Person is given notice of this continuation right by the Employer after the date his or her coverage would otherwise end, the written election and payment must be received by the Employer no later than 31 days after the date of notification. Subsequent monthly contributions required by the Employer must be paid to the Employer in advance, at the times and in the manner specified by the Employer.

The Employer will consider an Eligible Person's failure to give this notice or to pay any required monthly contribution as a waiver of his or her continuation rights.

The Employer's Responsibilities

At the time of employment, the Employer must notify the Covered Employee of his or her right to continue coverage.

At the time the Covered Employee goes on active duty, the Employer must notify each Eligible Person of: (a) his or her right to continue this Plan's group health benefits; (b) the monthly payment he or she must make to continue such benefits; and (c) the times and manner in which such monthly payments must be made.

The Monthly Payment

If the Covered Employee is on active duty for fewer than 31 days, he or she must pay the normal Covered Employee payment for the first month of coverage. Payment will be due by the end of the 31 days.

If the Covered Employee is on active duty for 31 days or more, he or she will be required to pay 102% of the full monthly payment under the Plan for each month, which represents the Employer's share plus the Covered Employee's share, plus 2% for administrative costs.

Payment of the initial payment must be made within 45 days of electing coverage. Thereafter, payment of a month's entire amount will be due on the first of each month. Payment that is not made within 31 days of the beginning of the month for which it is due will result in termination of coverage effective back to the first of the month that the payment was due. Any claims that were Incurred in such a month will be denied and a refund of payment will be sought if claims that were Incurred in that month were paid.

When Continuation Ends
An Eligible Person's continued group health benefits end on the first of the following: (a) the date the Eligible Person is enrolled in another group plan that does not contain a pre-existing condition exclusion or limitation that impacts the eligible person, not including being covered under the Civilian Health and Medical Program of the Uniformed Services; (b) the end of the 24 month continuation period; (c) the beginning of the month for which the last monthly contribution payment was due but went unpaid; or (d) the date this Plan ends and is not replaced.

When The Covered Employee Is Released From Active Duty
When the Covered Employee is released from active duty and timely returns to work for the Employer with whom he or she was employed when called to active duty, as required by USERRA, the Covered Employee and other eligible persons who were covered by this USERRA coverage will be reinstated in the Plan. No new Employment Waiting Period will be applied if coverage was continuous under this provision, except as set out below.

When the Covered Employee is released from active duty and returns to work for the Employer in a timely manner, as required by USERRA, and the Covered Employee's coverage was terminated during the Covered Employee's active service, coverage will be reinstated for the Covered Employee as well as for the spouse and Dependent child, if they were covered by the Plan at the time the Covered Employee went on active duty. No new Employment Waiting Period will be applied.

The Plan will exclude from coverage services for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of active service in the uniformed services. The determination that the Covered Employee's Sickness or Injury was incurred in, or was aggravated during, the performance of service may only be made by the Secretary of Veterans Affairs or his or her representative.

XIV. OTHER PROVISIONS

Plan Costs
The employer pays the balance of any premiums and administrative expenses out of its general assets. Where applicable, employee contributions toward the cost of coverage under the Plan are paid on a pre-tax basis through the Employer's cafeteria plan.

Conformity With Federal Statutes
If this Plan, on its Effective Date, is in conflict with any applicable federal laws, it is changed to meet the minimum requirements of those laws. In the event that new or applicable federal laws are enacted which conflict with current provisions of this SPD, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the SPD to the contrary.

Enforcement Of Plan Provisions
Failure by Us to enforce or require compliance with any provision within this SPD will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.

Required Data
You must furnish the Plan with all information with regard to this Plan that the Plan may reasonably require.

You may receive correspondence from the Employer or third-party administrator asking you to confirm or provide Social Security number information for your enrolled Dependents. Generally, Medicare requires the Plan's third-party administrators to provide this information to them electronically. To view the CMS (Centers for Medicare and Medicaid Services) ALERT, which provides information on the authority for requesting the Social Security number, visit www.cms.hhs.gov/MandatoryInsRep. Go to the Downloads section and select the *June 23, 2008 ALERT.*

The Employer must also obtain Social Security numbers for all enrolled Dependents to comply with new IRS reporting required by the Affordable Care Act.

Rescission
The Employer reserves the right to rescind coverage for a Covered Employee and/or Dependent if that person performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact with respect to the requirements for Plan coverage. Rescission is a retroactive cancellation of coverage. The Employer can also retroactively terminate coverage in other circumstances, including but not limited to non-payment of premiums or failure to report a dependent's loss of eligibility.

Before rescinding coverage and solely to the extent required by the Affordable Care Act (the "ACA"), the Employer will provide 30 days advance written notice of the rescission. However, the Employer can terminate medical coverage subject to the ACA without providing 30 days' advance written notice under certain circumstances permitted by the U.S. Department of Labor, including non-payment of premiums or failure to report a dependent's loss of eligibility.

Assignment
Except for voluntary assignments to health care providers, as may be required by law or as may be provided in applicable policies, your right to receive benefits under the Plan may not be assigned, voluntarily or involuntarily, to any other person.

Severability

If any clause or portion of this Health Care Plan Document and SPD is held invalid by a court of law or is otherwise unenforceable, the remaining provisions of this document shall not be invalid.

Legal Action
No cause of action, claim, or suit in law or in equity, may be brought to recover benefits under this Plan until the exhaustion of administrative remedies. You agree that You will not file a suit or legal action against Us for any breach of this agreement, or denial of benefits, without first submitting the dispute through the claims review process. No cause of action, claim, or suit in law or in equity can be brought later than 18 months from the date of the alleged breach of this agreement or denial of benefits, regardless of any statute of limitations to the contrary.

XV. STATEMENT OF ERISA RIGHTS

As a participant in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

1. *Receive Information About Your Plan And Benefits*
   Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including: insurance contracts; collective bargaining agreements; and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as detailed reports and SPD descriptions.

   Obtain copies of all Plan documents, other Plan information and an updated SPD upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.

   Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

2. *Continue Group Health Plan Coverage*
   Continue health care coverage for You, Your Covered Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your Covered Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries
In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called ''fiduciaries'' of the Plan, have a duty to do so prudently and in the interest of You and other Covered Persons and beneficiaries. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights
If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan Administrator and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $120 fine a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical Child support order, You may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful the

court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance With Your Questions
If You have any questions about Your Plan, you should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

XVI. NOTICE OF PRIVACY PRACTICES

This Notice Describes How Protected Health Information That Is Created Or Received By The Health Plan May Be Used And Disclosed And How A Covered Person Can Get Access To This Information. Please Review It Carefully.

A federal law called HIPAA requires that health plans and other covered entities (such as health care providers) protect the privacy of certain information. This Notice of Privacy Practices ("Notice") is intended to inform Covered Persons, in summary fashion, of their rights under HIPAA's privacy provisions and the HIPAA obligations imposed on the group health plan sponsored by their Employer ("Plan"). This Notice describes how protected health information ("PHI") may be used or disclosed by this Plan to carry out treatment, payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out this Plan's legal obligations concerning a Covered Person's protected health information, and describes a Covered Person's rights to access, amend and manage that protected health information.

Any reference to "We" or "Us" means the Plan.

Only Protected Health Information ("PHI") is covered by this Notice. Protected Health Information is individually identifiable health information, including demographic information, that is collected from a Covered Person, or created or received by a health care provider, a health plan, an employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: 1) a Covered Person's past, present, or future physical or mental health or condition; 2) the provision of health care to a Covered Person; or 3) the past, present, or future payment for the provision of health care to a Covered Person.

The Plan restricts access to PHI to those who "need to know that information" to provide services to Covered Persons, or on behalf of Covered Persons. Health Information that a Covered Person's employer receives about the Covered Person as an employer (or in a capacity other than as administrator of the Plan) is not PHI. Thus, a Covered Person's sick leave records, FMLA leave information, drug testing results, Workers' Compensation files, disability, life insurance, and OSHA records are not PHI and are not covered by this Notice.

This Notice has been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If You have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact the "Privacy Contact." The Privacy Contact will be designated by your Employer in another document.

Effective Date
This Notice of Privacy Practices becomes effective on January 1, 2014.

The Plan's Responsibilities
The Plan is required by law to maintain the privacy of a Covered Person's PHI. The Plan is obligated to provide the Covered Person with a copy of this Notice of the Plan's: 1) legal duties; 2) rights and obligations under HIPAA regarding a Covered Person's PHI; 3) privacy practices with respect to such PHI; 4) obligation to abide by the terms of the Notice that is currently in effect; and, 5) obligation to notify the Covered Person in the event of a breach of the Covered Person's unsecured PHI.

The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all PHI that it maintains. If the Plan makes a material change to this Notice, a revised Notice will be mailed to the address that the Plan has on record.

Genetic information shall be treated as health information pursuant to the Health Insurance Portability and Accountability Act. The use or disclosure by the Plan of protected health information that is genetic information about an individual for underwriting purposes under the Plan shall not be a permitted use or disclosure.

When using or disclosing PHI, or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to, or requests by, a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures that are required for compliance with the HIPAA Privacy Rule; and
- uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and, with respect to which, there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

Information Collected
The Plan may collect information directly from a Covered Person orally, or on an application or other form. The Plan also collects information from third parties, such as current or former health care providers, and consumer reporting agencies.

It is impossible to describe every type of information that may be collected, but here are some examples:

- A Covered Person's name, age, address, Social Security number, telephone number, occupation, and other demographic information;
- A Covered Person's history of other insurance coverage and applications (if applying online, information is collected through an Internet "cookie," an information-collecting device from a web server);
- A Covered Person's past, present, or future physical, mental, or behavioral health or condition;
- A Covered Person's health care history;
- A Covered Person's prescription information; and,
- Information about the Covered Person from consumer reporting agencies and data collection agencies.

Permissible Uses And Disclosures Of PHI
This section describes how the Plan is most likely to use and/or disclose a Covered Person's PHI. Please note that this Notice does not list every use or disclosure, instead it gives examples of the most common uses and disclosures.

- *Treatment, Payment And Health Care Operations*

The Plan has the right to use and disclose a Covered Person's PHI for all activities that are included within the definitions of "treatment," "payment," and "health care operations" as described in the applicable HIPAA Privacy Rule. Generally, this means that the Plan may use Your PHI for the following purposes:

The Plan may use or disclose PHI so that a Covered Person may seek medical treatment. Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to consultations and referrals between two or more of a Covered Person's providers. For example, the Plan may disclose to a treating specialist the name of a Covered Person's primary care physician so that the specialist may request medical records from that primary care physician. The Plan also may send health care information to doctors for patient safety or other treatment-related reasons.

The Plan may use and disclose PHI to pay claims for services provided to a Covered Person, and to obtain stop-loss reimbursements (if applicable), or to otherwise fulfill the Plan's responsibilities for coverage and providing benefits. For example, the Plan may disclose PHI when a provider requests information regarding a Covered Person's eligibility for coverage under this Plan, or the Plan may use PHI to determine if a treatment that was received was medically necessary. The Plan may also share PHI with a utilization review or pre-certification service provider. Likewise, the Plan may share medical information with another entity to coordinate payment of benefits (e.g., under the plan of the Covered Person's spouse). The Plan will also share PHI to assist with subrogation of a Covered Person's claims.

The Plan may use or disclose PHI to support its business functions. These functions include, but are not limited to: quality assessment and improvement; reviewing provider performance; licensing; stop-loss underwriting; cost management; business planning; and business development. For example, the Plan may use or disclose PHI: 1) to provide a Covered Person with information about a disease management program; 2) to respond to a customer service inquiry from a Covered Person; 3) in connection with fraud and abuse detection and compliance programs; 4) in connection with underwriting and soliciting bids from potential insurance carriers; 5) in connection with merger and acquisition activities; 6) in connection with setting monthly contributions, deciding employee monthly contributions, or submitting claims to the stop-loss (or excess loss) carrier; 7) to conduct or arrange for medical review; or, 8) in connection with legal services or audit services.

Required Disclosures Of PHI
The following is a description of disclosures that the Plan is required by law to make.

- *Disclosures To The Secretary Of The U.S. Department Of Health And Human Services*
  The Plan is required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

- *Disclosures To Covered Persons*
  The Plan is required to disclose to a Covered Person most of the PHI in a "designated record set" when that Covered Person requests access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. The Plan also is required to provide, upon the Covered Person's request, an accounting of most disclosures of his PHI that are for reasons other than treatment, payment and health care operations and are not disclosed through a signed authorization.

The Plan will disclose a Covered Person's PHI to an individual who has been designated by that Covered Person as his personal representative and who has qualified for such designation in accordance with relevant state law. However, before the Plan will disclose PHI to such a person, the Covered Person must submit a written notice of his designation, along with the documentation that supports his qualification (such as a power of attorney).

Even if the Covered Person designates a personal representative, the HIPAA Privacy Rule permits the Plan to elect not to treat that individual as the Covered Person's personal representative if a reasonable belief exists that: 1) the Covered Person has been, or may be, subjected to domestic violence, abuse or neglect by such person; 2) treating such person as his personal representative could endanger the Covered Person; or, 3) the Plan determines, in the exercise of its professional judgment, that it is not in its best interest to treat that individual as the Covered Person's personal representative.

The Plan may use or disclosure PHI to other family members who are covered under the Plan regarding a Covered Person's care or payment related to the care. If a Covered Person objects to the use or disclosure of PHI in communications with other family members covered under the Plan, please contact the Privacy Contact identified on the first page of this Notice.

- *Business Associates*
  The Plan contracts with individuals and entities ("Business Associates") to perform various functions on its behalf, or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, use or disclose PHI, but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard PHI. For example, the Plan may disclose PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation or pharmacy benefit management. Examples of the Plan's Business Associates would be its third party administrator, broker, preferred provider organization, and utilization review vendor.

- *Other Covered Entities*
  The Plan may use or disclose PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations in the areas of: fraud and abuse detection; compliance, quality assurance and improvement activities; or accreditation, certification, licensing or credentialing. This also means that the Plan may disclose or share PHI with other insurance carriers in order to coordinate benefits, if a Covered Person has coverage through another carrier.

- *Plan Sponsor*
  The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. Also, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

- *Plan Sponsor Personnel*
  The Plan may disclose PHI to certain employees of the Plan Sponsor ("Plan Sponsor Personnel"), who have been authorized by the Plan to receive PHI from or on behalf of the Plan, as necessary to

perform certain Plan administration functions on behalf of the Plan. Plan Sponsor Personnel are subject to the same restrictions as the Plan, and in no event may Plan Sponsor Personnel use PHI for employment related purposes.

Other Permissible Uses And Disclosures Of PHI
The following is a description of other possible ways in which the Plan may (and is permitted to) use and/or disclose PHI.

- *As Required By Law*
  The Plan may use or disclose PHI to the extent the federal, state or local law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, the Plan may disclose PHI when required by national security laws or public health disclosure laws.

- *Public Health Activities*
  The Plan may use or disclose PHI for public health activities that are permitted or required by law. For example, the Plan may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plan also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

- *Health Oversight Activities*
  The Plan may disclose PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: 1) the health care system; 2) government benefit programs; 3) other government regulatory programs; and 4) compliance with civil rights laws.

- *Abuse Or Neglect*
  The Plan may disclose PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, the Plan may disclose PHI to a governmental entity authorized to receive such information if there is reason to believe that the Covered Person has been a victim of abuse, neglect, or domestic violence.

- *Legal Proceedings*
  The Plan may disclose PHI: 1) in the course of any judicial or administrative proceeding; 2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and, 3) in response to a subpoena, a discovery request, or other lawful process, once the Plan has met all administrative requirements of the HIPAA Privacy Rule. For example, the Plan may disclose PHI in response to a subpoena for such information, but only after first meeting certain conditions required by the HIPAA Privacy Rule.

- *Law Enforcement*
  Under certain conditions, the Plan also may disclose PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: 1) it is required by law or some other legal process; 2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; or, 3) it is necessary to provide evidence of a crime.

- *Coroners, Medical Examiners, Funeral Directors, And Organ Donation Organizations*

The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, the Plan may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

- *Research*
  The Plan may disclose PHI to a third party for purposes of research when: 1) individual identifiers have been removed; or 2) an institutional review board or privacy board has: (a) reviewed the research proposal and established protocols to ensure the privacy of the information; and (b) approved the research.

- *To Prevent A Serious Threat To Health Or Safety*
  Consistent with applicable federal and state laws, the Plan may disclose PHI if there is reason to believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- *Military Activity And National Security, Protective Services*
  Under certain conditions, the Plan may disclose PHI if Covered Persons are, or were, Armed Forces personnel, for activities deemed necessary by appropriate military command authorities. If Covered Persons are members of foreign military service, the Plan may disclose PHI about foreign military personnel to the appropriate foreign military authority. The Plan also may disclose PHI to authorized federal officials for conducting national security and intelligence or counterintelligence, and for the protection of the President and other authorized persons or heads of state.

- *Inmates*
  If a Covered Person is an inmate of a correctional institution, the Plan may disclose PHI to the correctional institution or to a law enforcement official for: 1) the institution to provide health care to the Covered Person; 2) the Covered Person's health and safety and the health and safety of others; or 3) the safety and security of the correctional institution.

- *Workers' Compensation*
  The Plan may disclose PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

- *Emergency Situations*
  The Plan may disclose PHI of a Covered Person in an emergency situation, or if the Covered Person is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by the Covered Person. The Plan will use professional judgment and experience to determine if the disclosure is in the best interests of the Covered Person. If the disclosure is in the best interest of the Covered Person, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the care of the Covered Person.

  The Plan may also disclose PHI of a Covered Person to an entity assisting in a disaster relief effort so that the Covered Person's family can be notified about the Covered Person's condition, status, and location.

- *Fundraising Activities*
  The Plan may use or disclose the PHI of a Covered Person for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan does

contact the Covered Person for fundraising activities, the Plan will give the Covered Person the opportunity to opt-out, or stop, receiving such communications in the future.

- *Group Health Plan Disclosures*
  The Plan may disclose the PHI of a Covered Person to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to the Covered Person. The Plan can disclose the PHI of the Covered Person to that entity if that entity has contracted with the Plan to administer the Covered Person's health care program on its behalf.

- *Underwriting Purposes*
  The Plan may use or disclose the PHI of a Covered Person for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does use or disclose the PHI of the Covered Person for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process the PHI of the Covered Person that is genetic information.

- *Others Involved In Your Health Care*
  Using its best judgment, the Plan may make PHI known to a family member, other relative, close personal friend or other personal representative that the Covered Person identifies. Such use will be based on how involved the person is in the Covered Person's care or in the payment that relates to that care. The Plan may release information to parents or guardians, if allowed by law.

If a Covered Person is not present or able to agree to these disclosures of PHI, then, using its professional judgment, the Plan may determine whether the disclosure is in the Covered Person's best interest.

Uses And Disclosures Of PHI That Require A Covered Person's Authorization
Other uses and disclosures of PHI that are not described above will be made only with the Covered Person's written authorization. If the Covered Person provides the Plan with such an authorization, the Covered Person may revoke the authorization in writing, and the revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that the Plan already has used or disclosed in reliance on the authorization.

- *Sale Of PHI*

The Plan will request the written authorization of a Covered Person before the Plan makes any disclosure that is deemed a sale of the Covered Person's PHI, meaning that the Plan is receiving compensation for disclosing the PHI in this manner.

- *Marketing*
  The Plan will request the written authorization of a Covered Person to use or disclose the Covered Person's PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Covered Person, or when the Plan provides promotional gifts of nominal value.

- *Psychotherapy Notes*
  The Plan will request the written authorization of a Covered Person to use or disclose any of the Covered Person's psychotherapy notes that the Plan may have on file, with limited exception, such as for certain treatment, payment or health care operation functions.

Potential Impact Of State Law
The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent a law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy

Regulations, might impose a privacy standard under which the Plan will be required to operate. The privacy laws of a particular state or other federal laws might impose a stricter privacy standard. If these stricter laws apply, the Plan will comply with the stricter law. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

A Covered Person's Rights
The following is a description of a Covered Person's rights with respect to PHI:

- *Right To Request A Restriction*
  A Covered Person has the right to request a restriction on the PHI the Plan uses or discloses about him/her for treatment, payment or health care operations. To request restrictions, a Covered Person must make a written request to the Privacy Contact identified on the first page of this Notice. In the request, the Covered Person must include: 1) what information he/she wants to limit; 2) whether he/she wants to limit the use, disclosure, or both; and 3) to whom the Covered Person wants the limits to apply—for example, disclosures to the Covered Person's spouse.

  The Plan is not required to agree to any restriction that a Covered Person may request. If the Plan agrees to the restriction, it will comply with the restriction until it is revoked, or unless the information is needed to provide emergency treatment to the Covered Person.

- *Right To Request Confidential Communications*
  If a Covered Person believes that a disclosure of all or part of his/her PHI may endanger him/her, that Covered Person may request that the Plan communicates with him/her regarding PHI in an alternative manner, or at an alternative location. For example, the Covered Person may ask that the Plan only contact the Covered Person at a work address or via the Covered Person's work e-mail.

  To request a restriction, the Covered Person must make a written request to the Privacy Contact identified on the first page of this Notice. This written request should inform the Plan: 1) that he/she wants the Plan to communicate his PHI in an alternative manner, or at an alternative location; and, 2) that the disclosure of all or part of this PHI in a manner inconsistent with these instructions would put the Covered Person in danger.

  The Plan will accommodate a request for confidential communications that is reasonable, and that states that the disclosure of all or part of a Covered Person's PHI could endanger that Covered Person. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

  Accordingly, as a condition of granting a Covered Person's request, he/she will be required to provide the Plan information concerning how payment will be handled. For example, if the Covered Person submits a claim for payment, state or federal law (or the Plan's own contractual obligations) may require that the Plan disclose certain financial claim information to the Plan Participant under whose coverage a Covered Person may receive benefits (e.g., an Explanation of Benefits "EOB"). Unless the Covered Person has made other payment arrangements, the EOB (in which a Covered Person's PHI might be included) will be released to the Plan Participant.

  Once the Plan receives all the information for such a request (along with the instructions for handling future communications), the request will be processed usually within 2 business days or as soon as reasonably possible.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an EOB). Therefore, it is extremely important that the Covered Person contact the Privacy Contact as soon as the Covered Person determines the need to restrict disclosures of his/her PHI.

If the Covered Person terminates his request for confidential communications, the restriction will be removed for all of the Covered Person's PHI that the Plan holds, including PHI that was previously protected. Therefore, a Covered Person should not terminate a request for confidential communications if that person remains concerned that disclosure of PHI will endanger him/her.

- *Right To Inspect And Copy*
  A Covered Person has the right to inspect and copy PHI that is contained in a "designated record set." Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. However, the Covered Person may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

  To inspect and copy PHI that is contained in a designated record set, the Covered Person must submit a written request to the Privacy Contact identified on the first page of this Notice. If the Covered Person requests a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with that request.

  The Plan may deny a Covered Person's request to inspect and copy PHI in certain limited circumstances. HIPAA provides several important exceptions to a Covered Person's right to access PHI. For example, a Covered Person will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal or administrative action or proceeding. The Plan will not allow a Covered Person to access PHI if these or any of the exceptions permitted under HIPAA apply.

  If a Covered Person is denied access to PHI, he/she may request that the denial be reviewed. To request a review, the Covered Person must contact the Privacy Contact identified on the first page of this Notice.

  A licensed health care professional chosen by the Plan will review the Covered Person's request and the denial. The person performing this review will not be the same one who denied the Covered Person's initial request. Under certain conditions, the Plan's denial will not be reviewable. If this event occurs, the Plan will inform the Covered Person through the denial that the decision is not reviewable.

- *Right To Amend*
  If a Covered Person believes that his/her PHI is incorrect or incomplete, the Covered Person may ask the Plan to amend that information. The Covered Person may request that the Plan amend such information by submitting a written request to the Privacy Contact identified on the first page of this Notice. The request must list the specific PHI that needs amending, and explain why it is incorrect or incomplete.

  In certain cases, the Plan may deny the Covered Person's request for an amendment. For example, the Plan may deny the request if the information the Covered Person wants to amend is not maintained by the Plan, but by another entity. In addition, the Plan may deny a request if the Covered Person asks the Plan to amend information that:

  - is not part of the medical information kept by or for the Plan;

- was not created by the Plan or its third party administrators;
- is not part of the information which the Covered Person would be permitted to inspect and copy; or
- is accurate and complete.

If the Plan denies the request, they will provide a written explanation for the denial. The Covered Person has the right to file a written statement of disagreement with the Plan. This statement of disagreement will be linked with the disputed information, and all future disclosures of the disputed information will include this statement.

- *Right Of An Accounting*
  The Covered Person has a right to an accounting of certain disclosures of PHI that are for reasons other than treatment, payment or health care operations. An accounting will include the date(s) of the disclosure, to whom the Plan made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

  No accounting of disclosures is required for disclosures made pursuant to a signed authorization by the Covered Person or his personal representative. The Covered Person should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to this right.

  There also are other exceptions to this right. For example, the accounting will not include: 1) disclosures made to friends or family in the presence of a Covered Person, or because of an emergency; 2) disclosures for national security purposes; or, 3) disclosures incidental to otherwise permissible disclosures.

  To request an accounting of disclosures, a Covered Person must submit a written request to the Privacy Contact identified on the first page of this Notice. A Covered Person's request may be for disclosures made up to 6 years before the date of the request, but not for disclosures made before April 14, 2004. The first accounting requested within a 12-month period will be free. For additional lists of accounting, the Plan may charge for the costs of providing the list. The Plan will notify the Covered Person of the cost involved, and he/she may choose to withdraw or modify the request before any costs are incurred.

- *Right To Be Notified Of A Breach*
  The Plan is required by law to maintain the privacy and security of PHI. A Covered Person will be promptly notified if a breach occurs that may have compromised the privacy or security of PHI.

- *Right To A Copy Of This Notice*
  A Covered Person has the right to request a copy of this Notice by submitting a request to the Privacy Contact identified on the first page of this Notice. If a Covered Person has agreed to accept this Notice electronically, on the Plan's website or by electronic mail, he/she is also entitled to request a paper copy of this Notice at any time.

Complaints
A Covered Person may complain to the Plan if he/she believes that the Plan has violated these privacy rights. The Covered Person may file a complaint with the Plan by contacting the Privacy Contact identified on the first page of this Notice. A copy of a complaint form is available from this contact office.

A Covered person may also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by:

1. sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;

2. calling (877) 696-6775; or,

3. visiting the website at http://www.hhs.gov/ocr/privacy/index.html.

Complaints filed directly with the Secretary must: 1) be in writing; 2) contain the name of the entity against which the complaint is lodged; 3) describe the relevant problems; and (4) be filed within 180 days of the time the Covered Person became, or should have become, aware of the problem.

The Plan will not penalize or in any other way retaliate against a Covered Person for filing a complaint with the Secretary or with the Plan.

Changes To This Notice
The Plan reserves the right to make changes to this notice and to make the revised or changed notice effective for protected health information the Plan already has about You as well as any information the Plan receives or creates in the future. Any changes to this notice will be provided to You, and if the Plan makes substantial material changes to the notice, the Plan will distribute the revised notice to You.

XVII. OTHER NOTICES

Women's Health and Cancer Rights Act
Effective October 21, 1998, the Federal Women's Health and Cancer Rights Act requires all health care plans that provide coverage for a mastectomy must also provide coverage for the following medical care: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Covered benefits are subject to all provisions described in Your Plan, including but not limited to: Deductible, Copayment, Coinsurance, exclusions and limitations.

Newborns' and Mothers' Health Protection Act
Under federal law, the group health plan offering maternity or newborn infant coverage under this Plan cannot restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section, or require that a provider obtain authorization from the Plan or an insurer for prescribing a length of stay not in excess of the above periods. This requirement does not prevent an attending physician or other provider, in consultation with the mother, from discharging the mother or newborn child prior to the expiration of the applicable minimum period.

XVIII. DEFINITIONS GLOSSARY

When reading this Summary Plan Description (SPD), terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this Plan are defined below. Just because a term is defined does not mean it is covered. Please read the SPD carefully.

90-Day Prescription Drug Provider
A licensed pharmacy, including but not limited to a mail order service, that has agreed to Our terms and conditions, including reimbursement amounts, to provide 90-day supplies of covered Prescription Drugs under this plan.

Access Fee
An Access Fee only applies if it is shown in Your Benefit Summary. The Benefit Summary will identify what any applicable Access Fees are, along with the Covered Charges to which they apply.

An Access Fee is the amount of Covered Charges a Covered Person must pay each time Covered Charges are received.

The following Access Fees may apply to Covered Charges:

1. **Emergency Room Access Fee:** The dollar amount that must be paid directly to the facility for an Emergency Room visit.
2. **Recuro Health Virtual Services Access Fee:** The dollar amount that must be paid directly to Recuro Health Virtual Services prior to a virtual visit.

Accident or Accidental
Any event that meets all of the following requirements:

1. It causes harm to the physical structure of the body.

2. It results from an external agent or trauma.

3. It is the direct cause of a loss, independent of disease, bodily infirmity or any other cause.

4. It is definite as to time and place.

5. It happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

An Accident does not include harm resulting from a Sickness.

Acute Behavioral Health Inpatient Facility
A facility that provides acute care or Subacute Medical Care for Behavioral Health or Substance Abuse on an Inpatient basis. This type of facility must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by one of the following accreditations: The Joint Commission (TJC), Commission on the Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), Det Norske Ventius Healthcare, Inc. (DNV), The Accreditation Association for Ambulatory Health Care (AAAHC), Accreditation Commission for Health Care (ACHC), and the Healthcare Facilities Accreditation Program (HFAP) to provide acute care or Subacute Medical Care for Behavioral Health or Substance Abuse.

2. Be staffed by an on duty licensed physician 24 hours per day.

3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.

4. Maintain daily medical records that document all services provided for each patient.

5. Provide a restrictive environment for patients who present a danger to self or others.

6. Provide alcohol and chemical dependency detoxification services.

7. Handle medical complications that may result from a Behavioral Health or Substance Abuse diagnosis.

8. Not primarily provide Rehabilitative Services, residential, partial hospitalization or intensive Outpatient services although these services may be provided in a distinct section of the same physical facility.

Acute Medical Rehabilitation Facility
A facility that provides acute care for Rehabilitative Services for a Sickness or an Injury on an Inpatient basis. A distinct section of a Hospital solely devoted to providing acute care for Rehabilitative Services would also qualify as an Acute Medical Rehabilitation Facility. These types of facilities must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by one of the following accreditations: The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA), the Center for Improvement in Healthcare Quality (CIHQ) or Commission on Accreditation of Rehabilitation Facilities (CARF) to provide acute care for Rehabilitative Services.

2. Be staffed by an on duty physician 24 hours per day.

3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.

4. Provide an initial, clearly documented care plan upon admission and ongoing care plans for patients on a regular basis that include reasonable, appropriate and attainable short and intermediate term goals.

5. Provide a total of at least 3 hours per day of any combination of active Physical Therapy, Occupational Therapy and Speech Therapy by an appropriately licensed Health Care Practitioner to each patient at least 6 days per week. A Covered Person must be able and willing to participate actively in these services for at least the above referenced time frames. Cognitive therapy, counseling services, passive range of motion therapy, respiratory therapy and similar services are not included in the 3 hour minimum per day requirement of active Physical Therapy, Occupational Therapy and Speech Therapy.

6. Not primarily provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same physical facility.

Affordable Care Act (ACA)
The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and all applicable regulations and regulatory guidance.

Amount Generally Billed (AGB)
The maximum amount a hospital can collect from a patient who is eligible for financial assistance under the applicable Financial Assistance policy and is the Maximum Allowable Charge the Plan will pay for Participants who are eligible for financial assistance.

Ancillary Charge
The difference in cost between a Brand Name Drug and what the Plan will pay for a Generic Drug when a Generic Drug substitute exists but the Brand Name Drug is dispensed. A Covered Person must pay any applicable Ancillary Charge directly to the Participating Pharmacy or Specialty Pharmacy Provider.

Ancillary Charge also includes the difference in cost between a Brand Name Drug and Bio-Similar Drug when a Bio-Similar Drug substitute exists but the Brand Name Drug is dispensed.

The Ancillary Charge does not count toward satisfying any Coinsurance, Copayment, Deductible, or Out-of-Pocket Limit under any other section in this Plan.

Ancillary Pharmacy Network Charge
The difference in cost between the actual charge and the maximum amount that a Participating Pharmacy Only or Specialty Pharmacy Provider has agreed to accept as total payment for the cost of a Prescription Drug. The Covered Person must pay any applicable Ancillary Pharmacy Network Charge directly to the Pharmacy. An Ancillary Pharmacy Network Charge may apply if the Covered Person does not use his or her identification (ID) card to obtain Prescription Drugs at a Participating Pharmacy or Specialty Pharmacy Provider or if Prescription Drugs are purchased at a Non-Participating Pharmacy.

The Ancillary Pharmacy Network Charge does not count toward satisfying any Coinsurance, Copayment, Deductible or other Out-of-Pocket Limit.

Approved Clinical Trial
A clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

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

    a. The National Institutes of Health.
    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. Cooperative group or center of any of the entities described above, of 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, if the conditions for department are met.
    h. The Department of Defense, if the conditions for department are met.
    i. The Department of Energy, if the conditions for department are met.

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

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

Annual Open Enrollment Period
The period of time each year when an Employee or Dependent may enroll in the Plan.

Assistant Surgeon
A Health Care Practitioner who is qualified by licensure, training and credentialing to perform the procedure, in an assistant role to the primary surgeon, in the state and facility where the procedure is performed.

Average Sales Price
A published cost of a Prescription Drug as listed by the national drug data bank or by a federal or other national source used to administer the Plan on the date the Prescription Drug is purchased.

Average Wholesale Price
A published cost of a Prescription Drug that is paid by a Pharmacy to a wholesaler as listed by the national drug data bank used to administer the Plan on the date the Prescription Drug is purchased.

Aversion Therapy
A series of procedures, medications or treatments that are designed to reduce or eliminate unwanted or dangerous behavior through the use of negative experience, such as pairing the behavior with unpleasant sensations or punishment.

Behavioral Health
Any condition classified as a mental disorder in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by Us.

Behavioral Health Rehabilitation and Residential Facility
A facility that provides care for Behavioral Health or Substance Abuse on an Inpatient basis. This type of facility may also be referred to as a residential facility and must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by one of the following accreditations: The Joint Commission (TJC), Commission on the Accreditation of rehabilitation Facilities (CARF), Council on Accreditation (COA), Det Norske Ventius Healthcare , Inc. (DNV), The Accreditation Association for Ambulatory Health Care (AAAHC), Accreditation Commission for Health Care (ACHC), and the Healthcare Facilities Accreditation Program (HFAP) to provide residential care for Behavioral Health or residential/rehabilitation care for Substance Abuse.

2. Be staffed by an on call physician 24 hours per day.

3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.

4. Provide an initial evaluation by a physician upon admission and ongoing evaluations for patients on a regular basis.

5. Provide a restrictive environment for patients who present a danger to self or others.

6. Provide at least 3 hours per day of individual or group psychotherapy by an appropriately licensed Health Care Practitioner 6 days per week. Recreational therapy, educational therapy, music and dance therapy, exercise, yoga, equine therapy, and similar services are not included in the 3 hour minimum per day requirement of psychotherapy.

7. Be able to handle medical complications that may result from a Substance Abuse diagnosis.

8. Not primarily provide partial hospitalization or intensive Outpatient services although these services may be provided in a distinct section of the same physical facility.

Billing Period
The period of time beginning on the Monthly Plan Day of each month (as defined on the Benefit Summary) and ending on the day immediately preceding the Monthly Plan Day of the following month.

Bio-Similar Drug
An FDA-approved biological product that is nearly the same as another US-licensed reference biological product except for differences in clinically inactive components and for which there are no clinically meaningful differences in safety and potency between the biological product and the reference product.

Brand Name Drug
A Prescription Drug for which a pharmaceutical company has received a patent or trade name.

Calendar Year
The period beginning on January 1 of any year and ending on December 31 of the same year.

Cardiac Rehabilitation Program
An Outpatient program that is supervised by a Health Care Practitioner and directed at improving the physiological well-being of a Covered Person with heart disease.

Clinical Preventive Medications And Products
Prescription Drugs (as well as certain over-the-counter medications) and products required under the Affordable Care Act (ACA), for the following categories of preventive treatment:

1. **Evidence-Based Screenings and Counseling:** Evidence-based items or services for preventive care that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

2. **Routine Immunizations:** Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention, in accordance with the appropriate immunization schedule with respect to the Covered Person involved.

3. **Preventive Pediatric Health Care Services**: For infants, children, and adolescents, evidence-informed preventive screenings and assessments provided for in the comprehensive guidelines published by the American Academy of Pediatrics (AAP) and supported by the Health Resources and Services Administration (HRSA), in accordance with the recommended periodicity schedule of screenings and assessments applicable to the Covered Person involved.

4. **Preventive Health Care Services For Women:** For women, evidence-informed preventive care and screening provided for in the women's comprehensive preventive services guidelines supported by the HRSA, to the extent not already included in other recommendations of the USPSTF and/or HRSA.

Clinical Trial Qualified Individual
A Covered Person who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition and either:

1. The referring Health Care Practitioner is a Participating Provider and has concluded that the Covered Person's participation in such trial would be appropriate based on the trial protocol; or

2. The Covered Person provides medical and scientific information establishing that participation in such trial would be appropriate based upon the trial protocol.

Coinsurance or Plan Coinsurance
Coinsurance is the dollar amount or percentage of Covered Charges that must be paid by a Covered Person after any Copayment and Deductible are satisfied. Coinsurance applies separately to each Covered Person, except as otherwise provided by this SPD.

Coinsurance only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Coinsurance percentage or amount is along with the Covered Charges to which it applies.

Compounded Medication
A drug product made up of one or more active parts or ingredients which must be specially prepared by a licensed pharmacist pursuant to a Prescription Order. If covered, Compounded Medications will be considered to be Non-Preferred Brand Name Drugs.

Contracted Rate
The amount a Health Care Practitioner, facility, Participating Pharmacy, Specialty Pharmacy Provider or supplier that has a contract with the Plan or the Plan's Network Manager, as identified for this Plan, has agreed to accept as total payment for the treatment, services, or supplies or Prescription Drugs provided.

Copayment
A Copayment is the dollar amount that a Covered Person must pay to a Health Care Practitioner, Pharmacy, or facility each time certain visits or services are received. This amount does not count toward satisfying any Deductible or Coinsurance. A Copayment applicable to a Prescription Drug dispensation is subject to the Supply Limits outlined in the Outpatient Prescription Drug Benefits section. Covered Charges in the Medical Benefits section that require a Copayment are not subject to any Deductible, unless otherwise shown in the Benefit Summary.

A Copayment only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Copayments are along with the Covered Charges to which they apply.

Cosmetic Services
A surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.

Covered Charge
An expense that the Plan determines meets all of the following requirements:

1. It is Incurred for treatment, services or supplies provided by a Health Care Practitioner, facility or supplier.

2. It is Incurred by a Covered Person while coverage is in force under this Plan as the result of a Sickness or an Injury or for preventive medicine services or family planning services as outlined in the Medical Benefits section.

3. It is Incurred for services or supplies listed in the Medical Benefits section or Outpatient Prescription Drug Benefits section.

4. It is Incurred for treatment, services or supplies which are Medically Necessary.

5. It is not in excess of the Maximum Allowable Amount.

Charges from the Covered Person's Non-Participating Provider may exceed the Maximum Allowable Amount. The Covered Person is responsible for any amounts in excess of the Maximum Allowable Amount, as determined by the Plan.

Covered Dependent
A person who meets the definition of a Dependent and is eligible to receive benefits under this Plan.

Covered Employee
The Employee who participates in the Plan and is covered by benefits described in this SPD.

Covered Person
A person who is eligible to receive benefits under this Plan and for whom coverage is in effect based on enrollment approved by the Plan.

Currently Performing Services
You are an Employee of the Employer who regularly performs services for the Employer on a Full-Time Basis. Individuals Currently Performing Services do not include retirees or Employees on leave who are not expected to perform any duties, responsibilities or services for the Employer.

Custodial Care
Care, regardless of setting, that can be performed by persons without professional medical training and that is primarily for the purpose of meeting the personal needs of the patient. Custodial Care:

1. Does not contribute substantially to the improvement of a medical condition according to accepted medical standards; or

2. Is provided primarily to assist in the activities of daily living including, but not limited to, help in walking or getting in or out of bed; assistance with bathing, dressing, feeding, homemaking, or preparation of special diets; or supervision of medication which can usually be self-administered and does not entail or require the continuing services of licensed medical personnel; or

3. Is supportive in nature or primarily for the purpose of providing companionship or ensuring safety.

Deductible or Plan Deductible
A Deductible is the dollar amount of Covered Charges that must be paid before benefits are paid by the Plan.

This Plan has varying types of Deductibles. This may depend on whether the Covered Person's Health Care Practitioner belongs to a particular network or not. A particular Deductible only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Deductibles are along with the Covered Charges to which they apply.

One or more of the following Deductibles may apply to Covered Charges as shown in the Benefit Summary:

1. **Family Deductible:** The dollar amount that must be satisfied by all Covered Persons before benefits are payable by the Plan. The Individual Deductibles that all Covered Persons may have to pay are limited to the Family Deductible amount. When the Family Plan Deductible amount is reached, the Plan will consider the Deductible requirements for all Covered

Persons in Your family to be satisfied for the remainder of the Year. The Family Plan Deductible applies to Family Plans. If a Family Plan only includes two Covered Persons, each Covered Person must meet the Individual Deductible.

2. **Individual Deductible:** The dollar amount of Covered Charges each Covered Person must satisfy before benefits are payable by the Plan. When Covered Charges equal to the Individual Deductible have been Incurred and processed by the Plan, the Individual Deductible for that Covered Person will be satisfied for the remainder of the Year. Once a Covered Person's Individual Deductible is satisfied, Covered Charges for that Covered Person for the remainder of the Year will not count toward the Family Deductible.

3. **Integrated Deductible:** The shared dollar amount of Covered Charges Incurred by all Covered Persons that must be satisfied before benefits are payable by the Plan. When Covered Charges equal to the Integrated Deductible have been Incurred and processed by the Plan, the Integrated Deductible for all Covered Persons under the Plan will be satisfied for the remainder of the Year. The Individual Integrated Deductible applies to Single Plans. The Family Plan Integrated Deductible applies to Family Plans.

4. **Participating Provider Deductible:** The dollar amount of Covered Charges received from providers in the Health Care Provider Network that each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the Participating Provider Deductible have been Incurred and processed by Us, the Participating Provider Deductible for that Covered Person will be satisfied for the remainder of the Year. Any amount You pay toward satisfaction of the Participating Provider Deductible will not apply toward satisfaction of the Non-Participating Provider Deductible.

5. **Non-Participating Provider Deductible:** The dollar amount of Covered Charges received from Non-Participating Providers that each Covered Person must satisfy before benefits are payable by the Plan. When Covered Charges equal to the Non-Participating Provider Deductible have been Incurred and processed by the Plan, the Non-Participating Provider Deductible for that Covered Person will be satisfied for the remainder of the Year. Any amount You pay toward satisfaction of the Non-Participating Provider Deductible will not apply toward satisfaction of the Participating Provider Deductible.

Dental Injury
Injury resulting from an Accidental blow to the mouth causing trauma to teeth, the mouth, gums or supporting structures of the teeth.

Dental Treatment Plan
A dentist's report of recommended treatment on a form satisfactory to the Plan that:

1. Itemizes the dental procedures and charges required for care of the mouth; and

2. Lists the charges for each procedure; and

3. Is accompanied by supporting preoperative imaging tests and any other required appropriate diagnostic materials.

Dependent
A Dependent is:

1. The Employee's lawful spouse (or Domestic Partner, if applicable); or

2. A child, who is under 26 years of age, that is:

    a. the Employee's naturally born child;
    b. the Employee's legally adopted child;
    c. a child that is placed for adoption with the Covered Employee;
    d. a stepchild of the Covered Employee (or, if applicable, the Covered Employee's Domestic Partner's naturally born child or legally adopted child);
    e. a child for which the Covered Employee is the court appointed legal guardian; or
    f. a child for whom the Employee is required to provide medical coverage by court or qualified medical support order.

If an unmarried child is age 26 or older, the child will be considered a Dependent if You give Us proof that the child is not capable of self-sustaining employment or engaging in the normal and customary activities of a person of the same age because of mental incapacity or physical handicap. The child must also be chiefly dependent on the Covered Employee (or, if applicable, on the Covered Employee's Domestic Partner) for financial support. You must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this Plan, or within 31 days after the child reaches the normal age for termination. Additional proof may be requested periodically.

When the earliest of the following occurs – (1) the child attains age 26; or, (2) the child is over age 26 and is married or is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped – a child will no longer be a Dependent on the first Billing Period following such event.

Designated Gene Therapy Provider
A Participating Provider identified for this Plan as a Designated Gene Therapy Provider to provide Gene Therapy services to Covered Persons. A Participating Provider will only be considered a Designated Gene Therapy Provider when they are designated as such by the Plan for the specific Gene Therapy being obtained. This list is subject to change at any time without notice.

Designated Transplant Provider
A Participating Provider identified for this Plan as a Designated Transplant Provider to provide transplant services to Covered Persons. A Participating Provider will only be considered a Designated Transplant Provider when they are designated as such by the Plan for the specific transplant being obtained. The Designated Transplant Provider may not be located in the Covered Person's geographic area. This list is subject to change at any time without notice.

Developmental Delay
A child who has not attained developmental milestones for the child's age, adjusted for prematurity, in one or more of the following areas of development: cognitive; physical (including vision and hearing); communication; social-emotional; or adaptive development. A Developmental Delay is a delay that has been measured by qualified personnel using informed clinical opinion and appropriate diagnostic procedures and/or instruments. A Developmental Delay must be documented as:

1. A 12 month delay in one functional area; or

2. A 33% delay in one functional area or a 25% delay in each of two areas (when expressed as a quotient of developmental age over chronological age); or

3. A score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standard deviations below the mean in each of two functional areas if appropriate standardized instruments are individually administered in the evaluation.

Diagnostic Imaging
Procedures and tests including, but not limited to, x-rays, magnetic resonance imaging (MRI) and computerized axial tomography (CT), that are performed to diagnose a condition or determine the nature of a condition.

Domestic Partner
If the Employer's main office is located in a state that does not require coverage for Domestic Partners, the following definition and all references to Domestic Partner do not apply to this Plan.

If the Employer's main office is located in a state that lawfully requires Domestic Partner coverage, for purposes of this Plan, a Domestic Partner is defined as a person of the same or opposite gender who resides with the Employee in a long-term relationship of indefinite duration. The partners have an exclusive mutual commitment to be jointly responsible for each other's common welfare and share financial obligations. The Domestic Partner must meet all of the following requirements:

1. Be at least 18 years of age;

2. Be competent to enter into a contract; and

3. Not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which he or she legally resides.

A Domestic Partner must provide Us with an affidavit attesting that the domestic partnership has existed for a minimum period of 24 months at the time of enrollment under this Plan. Proof that the Domestic Partner relationship continues to exist will be requested by Us periodically.

Drug List
The list of Prescription Drugs and Clinical Preventive Medications and Products designated as eligible for benefit consideration under this Plan. The Drug List also shows the tier and benefit category assigned to a covered Prescription Drug or medication. The Drug List is subject to change at any time without notice.

Durable Medical Equipment
Equipment that meets all of the following requirements:

1. It is designed for and able to withstand repeated use.

2. It is primarily and customarily used to serve a medical purpose.

3. It is used by successive patients.

4. It is suitable for use at home.

5. It is normally rented.

Effective Date

The date coverage under this Plan begins for a Covered Person. The Covered Person's coverage begins on this date at 12:01 a.m. local time at the Covered Employee's state of residence. The Employer will provide confirmation of the Covered Person's Effective Date.

Eligibility Date
The date You and Your Dependents are first eligible to apply for coverage under this Plan.

Emergency Confinement
An Inpatient stay for a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention on an Inpatient basis to result in: 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment of bodily functions; or 3) serious dysfunction of any bodily organ or part.

Emergency Medical Condition
A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention to result in one of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;

2. Serious impairment to bodily function; or

3. Serious dysfunction of any bodily organ or part.

Emergency Room
A dedicated place or department that is affiliated with a Hospital and is used primarily for short term Emergency Treatment. An Emergency Room means any department or facility of the Hospital, regardless of whether it is located on or off the main Hospital campus, that meets at least one of the following requirements:

1. It is licensed under applicable State law, by the State in which the services are rendered, as an emergency room or emergency department and is accredited by one of the following accreditations: The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA), Det Norske Ventius Healthcare, Inc. (DNV), or the Center for Improvement in Healthcare Quality (CIHQ) to provide acute care or Subacute Medical Care;

2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for Emergency Medical Conditions on an urgent basis without requiring a previously scheduled appointment; or

3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its Outpatient visits for the treatment of Emergency Medical Conditions on an urgent basis without requiring a previously scheduled appointment.

An Emergency Room may also be referred to as an emergency department or a Hospital Outpatient department.

Emergency Services
With respect to an Emergency Medical Condition, emergency medical transportation services a medical screening examination that is within the capability of the Emergency Room staff and facility, and covered Inpatient or Outpatient Hospital services that are:

1. Furnished to a Covered Person in an Emergency Room by a provider who is qualified to furnish such services; and

2. Needed to evaluate or Stabilize an Emergency Medical Condition.

Emergency Treatment
Treatment, services or supplies for a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment of bodily functions; or 3) serious dysfunction of any bodily organ or part.

Employee
An Employee is an individual who:

1. Performs duties on a Full-Time Basis for the Employer; and

2. Receives monetary compensation from the Employer.

A person who is laid off, retired, a consultant or on the board of directors will not be considered an Employee.

Employment Waiting Period
As designated by the Employer, an Employment Waiting Period is:

1. A period of consecutive days during which You must be Currently Performing Services for the Employer before You are eligible to obtain coverage under this Plan; or

2. The period of time when a Covered Person's Effective Date is delayed because of the Plan's requirement that effective dates can fall only on a specific day of the month.

Employer
The Employer named in the Plan Administration Information section.

Enrollment Date
The Enrollment Date is:

1. The Employee's date of hire for an Employee or Dependent (if applicable) who enrolls during the first enrollment opportunity following the Employee's date of hire and any applicable Employment Waiting Period; or

2. The Employee's or Dependent's Effective Date for an Employee or a Dependent who enrolls during a Special Enrollment Period.

Experimental Or Investigational Services

Treatment, services, supplies or equipment which, at the time the charges are Incurred, that the Plan determines are:

1. Not proven to be of benefit for diagnosis or treatment of a Sickness or an Injury; or

2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury; or

3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or

4. Obsolete or ineffective for the treatment of a Sickness or an Injury; or

5. Medications used for non-FDA approved indications and/or dosage regimens.

For any device, drug, or biological product, final approval must have been received to market it by the Food and Drug Administration (FDA) for the particular Sickness or Injury. However, final approval by the FDA is not sufficient to prove that treatment, services or supplies are of proven benefit or appropriate or effective for diagnosis or treatment of a Sickness or an Injury. Any approval granted as an interim step in the FDA regulatory process, such as an investigational device exemption or an investigational new drug exemption, is not sufficient.

The determination as to whether charges are for Experimental Or Investigational Services is based on the following criteria:

1. Once final FDA approval has been granted, the usage of a device for the particular Sickness or Injury for which the device was approved will be recognized as appropriate if:

    a. It is supported by conclusive evidence that exists in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles; and
    b. The FDA has not determined the medical device to be contraindicated for the particular Sickness or Injury for which the device has been prescribed.

2. Once final FDA approval has been granted, the usage of a drug or biological product will be recognized as appropriate for a particular Sickness or Injury if the FDA has not determined the drug or biological product to be contraindicated for the particular Sickness or Injury for which the drug or biological product has been prescribed and the prescribed usage is recognized as appropriate medical treatment by:

    a. The American Medical Association Drug Evaluations; or
    b. The American Hospital Formulary Service Drug Information; or
    c. The United States Pharmacopeia Drug Information; or
    d. Conclusive evidence in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles.

3. For any other treatment, services or supplies, conclusive evidence from generally accepted peer-reviewed literature must exist that:

    a. The treatment, services or supplies have a definite positive effect on health outcomes. Such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale; and

b. Over time, the treatment, services or supplies lead to improvement in health outcomes which show that the beneficial effects outweigh any harmful effects; and
c. The treatment, services or supplies are at least as effective in improving health outcomes as established technology, or are useable in appropriate clinical contexts in which established technology is not employable.

Family Plan
Plan coverage issued to an eligible Employee and one or more of the eligible Employee's Dependents. The Employer will provide confirmation of the Covered Persons under this Plan.

Financial Assistance
For costs that a hospital ordinarily charges a fee, but which is provided free or at a reduced rate to patients who cannot afford to pay but who are not eligible for public programs such as Medicare or Medicaid and who qualify for a free or reduced rate in accordance with the hospital's financial assistance policy.

Free-Standing Facility
A facility that provides interventional services, on an Outpatient basis, which require hands-on care by a physician and includes the administration of general or regional anesthesia or conscious sedation to patients. This type of facility may also be referred to as an ambulatory surgical center, an interventional diagnostic testing facility, a facility that exclusively performs endoscopic procedures or a dialysis unit. A designated area within a Health Care Practitioner's office or clinic that is used exclusively to provide interventional services and administer anesthesia or conscious sedation is also considered to be a Free-Standing Facility. Room and board and overnight services are not covered. These facilities must meet all of the following requirements:

1. Be licensed by the state in accordance with the laws for the specific services being provided in that facility and be accredited by one of the following accreditations: The Joint Commission (TJC), The Accreditation Association for Ambulatory Health Care (AAAHC), American Association of Ambulatory Surgery Facilities (AAAASF) or the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA).

2. Not primarily provide care for Behavioral Health or Substance Abuse or be an Urgent Care Facility.

Full-Time Basis
An Employee who works at least the minimum hours per week, as required by the Employer and/or applicable law. If You have a question about this Plan's required minimum hours, please contact the Plan Administrator. A temporary, seasonal or part-time Employee will not be considered a full-time Employee unless required by law.

Gene Therapy
The therapeutic delivery of an FDA-approved pharmaceutical product to treat or cure disease through:

1. Replacing a disease causing gene with a healthy copy of the gene;

2. Inactivating a disease causing gene that may not be functioning properly; or

3. Introducing a new or modified gene into the body to help treat a disease.

Generic Drug
A Prescription Drug that:

1. Has the same active ingredients as an equivalent Brand Name Drug or that can be used to treat the same condition as a Brand Name Drug; and

2. Does not carry any drug manufacturer's brand name on the label; and

3. Is not protected by a patent.

It must be listed as a Generic Drug by the national drug data bank used to administer the Plan on the date it is purchased. Compounded Medications are not Generic Drugs. Medications that are commercially manufactured together and/or packaged together are not considered to be Generic Drugs, unless the entire combination product is specifically listed as a Generic Drug product by the national drug data bank used to administer the Plan on the date it is purchased.

Health Care Practitioner
A person licensed by the state or other geographic area in which the Covered Charges are rendered to treat the kind of Sickness or Injury or provide preventive or wellness services for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed. This would also include mid-level Health Care Practitioner. A mid-level Health Care Practitioner is an individual with advanced education and experience in the direct care of patients with an emphasis on primary care. A mid-level Health Care Practitioner includes physician assistants, nurse midwives and nurse practitioners. A mid-level Health Care Practitioner must be licensed or certified by the state or other geographic area in which the Covered Charges are rendered to treat the kind of Sickness or Injury for which a claim is made. The mid-level Health Care Practitioner must be practicing within the limits of his or her license or certification and in the geographic area in which he or she is licensed or certified.

Health Care Provider Network
The group of Health Care Practitioners, facilities and suppliers, identified by Us or the Network Manager for this Plan, who have agreed to accept a Contracted Rate as payment in full for specific treatment, services or supplies. For Specialty Pharmaceuticals obtained through a Pharmacy, only Specialty Pharmacy Providers identified by this Plan, who have agreed to accept a Contracted Rate as payment in full for specific Specialty Pharmaceuticals, are considered members of the Health Care Provider Network. This list is subject to change at any time without notice.

Home Health Care
Services provided by a state licensed Home Health Care Agency as part of a program for care and treatment in a Covered Person's home.

Home Health Care Agency
An organization:

1. Whose primary purpose is to provide Home Health Care; and

2. That is accredited by The Joint Commission (TJC), the Community Health Accreditation Partner (CHAP), or the Accreditation Commission for Health Care (ACHC); and

3. Which is licensed as a Home Health Care Agency by the state in which it provides services.

Hospice

An organization that provides medical services in an Inpatient, Outpatient or home setting to support and care for persons who are terminally ill with a life expectancy of 6 months or less as certified by a physician. A Hospice must meet all of the following requirements:

1. Comply with all state licensing requirements.

2. Provide a treatment plan and services under the direction of a physician.

An Inpatient Hospice facility must meet all of the following requirements in addition to the requirements above:

1. Be a dedicated unit within a Hospital or a Subacute Rehabilitation Facility or a separate facility that provides Hospice services on an Inpatient basis.

2. Be licensed by the state in which the services are rendered to provide Inpatient Hospice services.

3. Be staffed by an on call physician 24 hours per day.

4. Provide nursing services supervised by an on duty registered nurse 24 hours per day.

5. Maintain daily clinical records.

6. Admit patients who have a terminal illness.

7. Not provide patients with services that involve active intervention for the terminal illness although ongoing care for comorbid conditions and palliative care for the terminal illness may be provided.

Hospital (Acute Medical Facility)
A facility that provides acute care or Subacute Medical Care for a Sickness or an Injury on an Inpatient basis. This type of facility may also be referred to as a subacute medical facility or a long term acute care facility and must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by one of the following accreditations: The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA), Det Norske Ventius Healthcare, Inc. (DNV), or the Center for Improvement in Healthcare Quality (CIHQ) to provide acute care or Subacute Medical Care.

2. Be staffed by an on duty physician 24 hours per day.

3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.

4. Maintain daily medical records that document all services provided for each patient.

5. Provide immediate access to appropriate in-house laboratory and imaging services.

6. Not primarily provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same physical facility.

7. Provide care in an intensive care unit (ICU), a neonatal intensive care unit (NICU), a coronary intensive care unit (CICU) and step-down units.

Immediate Family Member
An Immediate Family Member is:

1. You or Your spouse (or Domestic Partner, if applicable); or

2. The children, brothers, sisters and parents of either You or Your spouse (or Domestic Partner, if applicable); or

3. The spouses of the children, brothers and sisters of You and Your spouse; or

4. Anyone with whom a Covered Person has a relationship based on a legal guardianship.

Incur or Incurred
The date services are provided or supplies are received.

Injury
Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally.

Inpatient
Admitted to a Hospital or other licensed facility for a stay of at least 24 hours for which a charge is Incurred for room and board or observation.

Intensive Outpatient Behavioral Health Program
A program that provides care for Behavioral Health or Substance Abuse on an Outpatient basis. Room and board and overnight services are not covered. This type of program must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by one of the following accreditations: The Joint Commission (TJC), Commission on the Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), Det Norske Ventius Healthcare, Inc. (DNV), The Accreditation Association for Ambulatory Health Care (AAAHC), Accreditation Commission for Health Care (ACHC) or the Healthcare Facilities Accreditation Program (HFAP) to provide care for Behavioral Health or Substance Abuse.

2. Provide at least 2 hours of individual or group psychotherapy a day by an appropriately licensed Health Care Practitioner at least 3 days per week. Recreational therapy, educational therapy, music and dance therapy, exercise, yoga, equine therapy and similar services are not included in the 6 hour minimum per week requirement of psychotherapy.

Mail Service Prescription Drug Vendor
A Participating Pharmacy that is under contract with the Plan or the Network Manager through the Plan's Participating Pharmacy Network. The Mail Service Prescription Drug Vendor dispenses selected Prescription Maintenance Drugs to Covered Persons through the mail.

Malocclusion
Teeth that do not fit together properly which creates a bite problem.

Mandibular Protrusion Or Recession
A large chin which causes an underbite or a small chin which causes an overbite.

Maxillary Or Mandibular Hyperplasia

Excess growth of the upper or lower jaw.

Maxillary Or Mandibular Hypoplasia
Undergrowth of the upper or lower jaw.

Maximum Allowable Amount
The maximum amount of a billed charge considered when determining Covered Charges, as determined by the Plan. Benefit payments of Covered Charges are based on what the Plan determines to be the Maximum Allowable Amount. Amounts billed in excess of the Maximum Allowable Amount by or on behalf of a Health Care Practitioner, facility or supplier are not payable by the Plan. Please see the Provider Charges and Maximum Allowable Amount Provisions section for the method(s) used to determine the Maximum Allowable Amount.

Maximum Allowable Cost (MAC) List
A list of Prescription Drugs that are considered for reimbursement at a Generic Drug product level established by the Plan. This list is subject to change at any time without notice.

Maximum Benefit
The maximum amount, as shown in the Benefit Summary, that the Plan will pay for Covered Charges Incurred by each Covered Person as set forth in this SPD. When the Maximum Benefit has been reached, no other benefits are considered as Covered Charges for that Covered Person for the treatment, services, or supplies to which the maximum applies.

Medical Review Manager
The Plan, or designated organization or entity, which may:

1. Review services as required by the Utilization Review Provisions section; or

2. Perform discharge planning and case management services; or

3. Evaluate the Medical Necessity of treatment, services or supplies; or

4. Administer treatment for Behavioral Health or Substance Abuse through Health Care Practitioners, facilities or suppliers; or

5. Review a Covered Person's Behavioral Health or Substance Abuse condition and evaluate the Medical Necessity of referral treatment; or

6. Review and administer authorization under the Specialty Pharmacy Program.

Medical Supplies
Disposable medical products or Personal Medical Equipment that are used alone or with Durable Medical Equipment.

Medical Supply Provider
Agencies, facilities or wholesale or retail outlets that make medical supplies available for use.

Medically Necessary or Medical Necessity
Treatment, services or supplies that are rendered to diagnose or treat a Sickness or an Injury. Medical Necessity does not include care that is prescribed or provided on the recommendation of a Covered Person’s Immediate Family Member. The Plan must determine that such care:

1. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment of the Sickness or Injury; and

2. Is commonly accepted as proper care or treatment of the condition in accordance with United States medical practice and federal government guidelines; and

3. Can reasonably be expected to result in or contribute substantially to the improvement of a condition resulting from a Sickness or an Injury; and

4. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of medical care provided.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make the treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this Plan.

Medicare
Any portion of Title XVIII of the United States Social Security Act of 1965, as amended.

Negotiated Rate
The amount negotiated between Us, or the Network Manager on behalf of Us, and the Health Care Practitioner, Pharmacy, facility or supplier as total payment for the services, Prescription Drugs (including Specialty Pharmaceuticals) or supplies provided The Negotiated Rate may include any discount arrangement We may have with the Health Care Practitioner, Pharmacy, facility or supplier.

Network Manager
An organization or entity designated by the Plan Sponsor, which may administer the Health Care Provider Network, Participating Pharmacy Network, and/or Specialty Pharmacy Network.

Non-Participating Pharmacy
A Pharmacy that is not under contract with the Network Manager to provide Prescription Drugs to the Covered Person through the Participating Pharmacy Network or Specialty Pharmacy Network.

Non-Participating Provider
Any Health Care Practitioner, facility or supplier, not identified by the Network Manager, as participating.

Non-Preferred Brand Name Drug
A Brand Name Drug that is not listed as preferred in the Drug List.

Occupational Therapy
The treatment of Sickness or Injury, by a Health Care Practitioner who is an occupational therapist, using purposeful activities or assistive devices that focus on all of the following:

1. Developing daily living skills.

2. Strengthening and enhancing function.

3. Coordination of fine motor skills.

4. Muscle and sensory stimulation.

Occupational Therapy also includes aquatic therapy as part of an approved Occupational Therapy regimen.

Office Visit
An in-person meeting between a Covered Person and a Health Care Practitioner in the Health Care Practitioner's office, or a Telehealth (virtual) visit between a Covered Person and a Health Care Practitioner. During this meeting, the Health Care Practitioner evaluates and manages the Covered Person's Sickness or Injury, including Behavioral Health and Substance Abuse disorders, as defined in the most recent edition of Current Procedural Terminology (CPT) or provides preventive medicine services. Office Visit does not include Physical Therapy, Speech Therapy, or Occupational Therapy, even if rendered in an office setting or via Telehealth. Office Visit does not include any separately billed facility fee.

Orthognathic Treatment
Malocclusion, Mandibular Protrusion Or Recession, Maxillary Or Mandibular Hyperplasia, or Maxillary Or Mandibular Hypoplasia. Refer to the Definitions of these conditions in this section of the Plan.

Out-of-Pocket Limit
The Out-of-Pocket Limit is the sum of the Covered Charges each Year for which We do not pay benefits because of any applicable Deductible, Coinsurance or Copayments. When Covered Charges equal to the Out-of-Pocket Limit have been Incurred and processed by Us, the Out-of-Pocket Limit will be satisfied for the remainder of the Year. The Out-of-Pocket Limit applies separately to each Covered Person, except as otherwise provided by this Plan.

The following do not count toward satisfying any Out-of-Pocket Limit:

1. All penalties applied under the Utilization Review Provisions section.

2. Amounts not paid by the Plan due to the difference between the Non-Participating Provider benefit and the benefit that would have been paid had a Participating Provider been used.

3. Amounts in excess of the Maximum Allowable Amount.

4. Charges Incurred after the Maximum Benefit has been paid for a benefit under this Plan.

5. All Ancillary Charges.

6. All charges for Specialty Pharmaceuticals obtained from a Pharmacy that is not a Specialty Pharmacy Provider.

7. All charges that are not Covered Charges.

The Benefit Summary identifies the following Out-of-Pocket Limits, if applicable:

1. **Family Out-of-Pocket Limit:** The total dollar amount of Covered Charges that must be paid by You and Your Covered Dependents before We will consider the Out-of-Pocket Limit for all Covered Persons under the same Family Plan to be satisfied.

2. **Individual Out-of-Pocket Limit:** The dollar amount of Covered Charges that must be paid by each Covered Person before the Out-of-Pocket Limit is satisfied for that Covered Person.

3. **Non-Participating Provider Out-of-Pocket Limit:** The dollar amount of Covered Charges for services received from Non-Participating Providers that must be paid by each Covered Person before the Non-Participating Provider Out-of-Pocket Limit is satisfied for that Covered Person.

4. **Participating Provider Out-of-Pocket Limit:** The dollar amount of Covered Charges for services received from Participating Providers that must be paid by each Covered Person before the Participating Provider Out-of-Pocket Limit is satisfied for that Covered Person.

Outpatient
Treatment, services or supplies received at a licensed medical facility, Health Care Practitioner's office or dispensary on other than an Inpatient basis for a stay of less than 24 hours.

Partial Hospital and Day Treatment Behavioral Health Facility or Program
A program that provides care for Behavioral Health or Substance Abuse on an Outpatient basis. Room and board and overnight services are not covered. This type of program must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by one of the following accreditations: The Joint Commission (TJC), Commission on the Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), Det Norske Ventius Healthcare, Inc. (DNV), The Accreditation Association for Ambulatory Health Care (AAAHC), Accreditation Commission for Health Care (ACHC), the Healthcare Facilities Accreditation Program (HFAP)to provide care for Behavioral Health or Substance Abuse.

2. Provide at least 4 hours of individual or group psychotherapy a day by an appropriately licensed Health Care Practitioner 3-5 days per week. Recreational therapy, educational therapy, music and dance therapy, exercise, yoga, equine therapy, and similar services are not included in the 12 hour minimum per week requirement of psychotherapy.

Participating Pharmacy
A Pharmacy that is under contract with the Network Manager to provide Prescription Drugs to the Covered Person through the Participating Pharmacy Network or Specialty Pharmacy Network.

Participating Pharmacy Network
A Prescription Drug delivery system established by the Network Manager in which Participating Pharmacies are under contract with the Network Manager. The list of Participating Pharmacies is subject to change at any time without notice.

Participating Provider
Any Health Care Practitioner, facility or supplier that is:

1. Identified for this Plan by the Network Manager, as participating; and

2. Who has agreed to accept a Contracted Rate as payment in full for specific treatment, services or supplies.

This list is subject to change at any time without notice. The Health Care Provider Network may be made up of various levels of provider networks.

Participating Provider Network
The group of Participating Providers within the Health Care Provider Network, identified for this Plan by the Network Manager, who have agreed to accept a Contracted Rate as payment in full for specific treatment, services or supplies. For purposes of obtaining Specialty Pharmaceuticals through a Pharmacy under the Outpatient Prescription Drug Benefits section, only Specialty Pharmacy Providers are considered members of the Participating Provider Network. This list is subject to change at any time without notice.

Period Of Confinement
The initial and subsequent Inpatient stays resulting from the same or a related Sickness or Injury and/or any complications unless the current Inpatient stay begins more than 30 days after the date of discharge from the most recent Inpatient stay.

Personal Medical Equipment
Equipment, such as a prosthesis, that meets all of the following:

1. Is designed for and able to withstand repeated use; and

2. Is primarily and customarily provided to serve a medical purpose; and

3. Is not intended for use by successive patients.

Pharmacy
A licensed establishment where Prescription Drugs are dispensed by a licensed pharmacist in accordance with all applicable state and federal laws.

Physical Medicine
Treatment of physical conditions relating to bone, muscle or neuromuscular pathology. This treatment focuses on restoring function using mechanical or other physical methods.

Physical Therapy
The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a physical therapist, using therapeutic exercise and other services that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and alleviating pain. Physical Therapy also includes aquatic therapy and/or massage therapy as part of an approved Physical Therapy regimen.

Plan
The health care plan provided by Your Employer, established by this Plan Document and evidenced by the SPD.

Plan Administrator
The Employer, or a person or entity chosen by the Employer, to administer the group health plan.

Plan Effective Date
The date coverage under this Plan becomes available. The Plan Effective Date may or may not coincide with the Effective Date for a Covered Person. Coverage for a Covered Person is effective only when the Covered Person becomes eligible and enrolled under this Plan as of the Effective Date for that Covered Person.

Plan Year

The 12-month period shown on the Plan Information section during which this Plan is in force.

Prescription Card Service Administrator (PCSA)
An organization or entity that administers the processing of claims under the Outpatient Prescription Drug Benefits section. This organization or entity may be changed at any time without notice.

Prescription Drug
Any medication that:

1. Has been fully approved by the Food and Drug Administration (FDA) for marketing in the United States; and

2. Can be legally dispensed only with the written Prescription Order of a Health Care Practitioner in accordance with applicable state and federal laws; and

3. Contains the legend wording: "Caution: Federal Law Prohibits Dispensing Without Prescription" or “Rx Only” on the manufacturer's label, or similar wording as designated by the FDA.

Prescription Drugs include those used for contraception that are oral contraceptives, contraceptive patches, contraceptive vaginal rings, and diaphragms that are identified as covered contraceptives under the Affordable Care Act and identified on the Drug List.

Prescription Drug Copayment
A Prescription Drug Copayment is the dollar amount of Covered Charges that a Covered Person pays each time a Prescription Order is received that is covered under the Outpatient Prescription Drug Benefits section after any applicable Prescription Drug Deductible is satisfied. The Covered Person must pay any applicable Prescription Drug Copayment directly to the Participating Pharmacy or Specialty Pharmacy Provider.

A Prescription Drug Copayment only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Prescription Drug Copayments are along with the Prescription Drug Class to which they apply. A Prescription Drug Copayment applies toward any applicable Out-of-Pocket Limit.

Prescription Maintenance Drugs
Prescription Drugs that are:

1. Oral contraceptives or drugs that are taken regularly to treat a chronic health condition; and

2. Covered under this Outpatient Prescription Drug Benefits section; and

3. Approved for coverage under the 90-Day Prescription Drug Provider provision in the Outpatient Prescription Drug Benefits section.

Prescription Order
The request by a Health Care Practitioner for:

1. Each separate Prescription Drug and each authorized refill; or

2. Insulin or insulin derivatives only by prescription; or

3. Any one of the following supplies used in the self-management of diabetes and purchased during the same transaction only by prescription:

   a. Disposable insulin syringes and needles; or
   b. Disposable blood/urine/glucose/acetone testing agents or lancets.

Primary Care Practitioner
A Health Care Practitioner who is a general caregiver and includes general and family practitioners, internists, pediatricians, obstetricians and gynecologists; or who is designated by the Network Manager as a Primary Care Practitioner. A Health Care Practitioner who primarily treats Behavioral Health or Substance Abuse disorders is also considered a Primary Care Practitioner. A Primary Care Practitioner cannot be a Specialty Care Provider.

Qualified Treatment Plan
The plan or plans of treatment using evidence-based therapy and/or clinical procedures. The treatment plan(s) must be prescribed by a doctor or designed by a psychologist and approved by the Medical Review Manager before any services will be covered under this Policy. If there are multiple plans or components within a plan, all services must be coordinated to ensure efficacy of care and non-duplication of treatment. Multiple plans or components within a plan will be reviewed by and may be approved or disapproved independent of each other.

Recuro Health Urgent Care Visit
A meeting between a Covered Person and licensed provider to diagnose, treat and prescribe medication (when Medically Necessary) for a Covered Person's non-emergency medical condition.

Recuro Health Counseling Visit
A meeting between a Covered Person, age 10 years old and up, and a licensed therapist to provide assistance with a Covered Person's mental and emotional health concerns.

Recuro Health Psychiatry Visit
A meeting between a Covered Person, age 14 years old and up, and a licensed psychiatrist to provide assistance with a Covered Person's mental and emotional health concerns.

Rehabilitation Services
Specialized treatment for a Sickness or an Injury which meets all of the following requirements:

1. Is a program of services provided by one or more members of a multi-disciplinary team.

2. Is designed to improve the patient's function and independence.

3. Is under the direction of a qualified Health Care Practitioner.

4. Includes a formal written treatment plan with specific attainable and measurable goals and objectives.

5. May be provided in either an Inpatient or Outpatient setting.

Retail Health Clinic
A facility that meets all of the following requirements:

1. Is licensed by the state in accordance with the laws for the specific services being provided in that facility;

2. Is staffed by a Health Care Practitioner in accordance with the laws of that state;

3. Is attached to or part of a store or retail facility;

4. Is separate from a Hospital, Emergency Room, Acute Medical Rehabilitation Facility, Free-standing Facility, Skilled Nursing Facility, Subacute Rehabilitation Facility, or Urgent Care Facility, and any Health Care Practitioner's office located therein, even when services are performed after normal business hours;

5. Provides general medical treatment or services for a Sickness or Injury, or provides preventive medicine services;

6. Does not provide room and board or overnight services; and

7. Does not include Telehealth services or telemedicine services.

Routine Patient Costs
Covered Charges associated with participation in an Approved Clinical Trial. Routine Patient Costs do not include:

1. The investigational item, device, or service, itself;

2. Treatment, services and supplies that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Covered Person; or

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

Service Area
The defined geographic area served by Participating Providers. Contact the Network Manager to determine the precise geographic area serviced by Participating Providers. The Service Area is subject to change at any time without notice.

Sickness
A disease or illness of a Covered Person. For purposes of this Plan, Sickness includes Behavioral Health and Substance Abuse disorders. Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness.

Single Plan
Plan coverage issued to an eligible Employee for benefit of only one Covered Person. The Employer will provide confirmation of the Covered Person under this Plan.

Skilled Nursing Facility
A facility that provides continuous skilled nursing services on an Inpatient basis for persons recovering from a Sickness or an Injury. The facility must meet all of the following requirements:

1. Be licensed by the state in which services are rendered and accredited by one of the following: The Joint Commission (TJC) or Commission on Accreditation of Rehabilitation Facilities (CARF) to provide skilled nursing services.

2. Be staffed by an on call physician 24 hours per day.

3. Provide skilled nursing services supervised by an on duty registered nurse 24 hours per day.

4. Maintain daily clinical records.

Not primarily be a place for rest, for the aged or for Custodial Care or provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same physical facility. The facility may also provide extended care or Custodial Care which would not be covered under this Plan.

Special Enrollment Period
A period of time, lasting thirty-one (31) days, during which eligible Employees may apply for coverage under this Plan for themselves and their eligible Dependents outside of the Initial Enrollment Period and the Annual Open Enrollment Period. A Special Enrollment Period will be granted and commence:

1. On the day of the Covered Employee's marriage; or

2. On the day the Covered Employee acquires a Dependent child through birth, adoption, placement for adoption, or legal guardianship (if applicable); or

3. On the day a court orders coverage to be provided under this Plan for a Dependent spouse or child; or

4. On the day after the Employee terminates coverage under another group health plan or other health insurance coverage if:

    a. The Employee and/or Dependents were covered by another group health plan or other health insurance coverage when they were first eligible to apply for coverage under this Plan, or during the last open enrollment period; and
    b. The Employee previously waived coverage under this Plan because of being covered by another group health plan or other health insurance coverage; and
    c. The group health plan or other health insurance coverage described in item a. above:
        i. Was under either the Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation provision and the period for which coverage could be continued had been exhausted; or
        ii. Terminated as a result of loss of eligibility for coverage due to legal separation, divorce, death, termination of employment, reduction in the number of qualifying hours of employment or termination of employer contributions toward the coverage; or

5. On the day after the Covered Person terminates coverage under Medicaid or a State Child Health Insurance Plan (SCHIP) if coverage is terminated due to the loss of eligibility for coverage. The Covered Person must request coverage under this Plan no later than 60 days after the date of termination; or

6. On the day the Covered Person becomes eligible for assistance under Medicaid or a State Child Health Insurance Plan (SCHIP). The Covered Person must request coverage under this Plan no later than 60 days after the date of termination.

Specialty Care Provider
A Health Care Practitioner who is classified as a specialist by the American Boards of Medical Specialties or who is designated by the Network Manager as a Specialty Care Provider. A Specialty Care Provider does not include a Primary Care Practitioner, physical therapist, speech therapist, or occupational therapist.

Specialty Pharmaceuticals
These types of Prescription Drugs may include:

1. Drugs used to treat rare or certain chronic diseases.

2. Drugs that have a highly targeted, cellular mechanism of action.

3. Drugs that may require injection or other parenteral or unique method of administration.

4. Drugs that may require special administration and monitoring.

5. Drugs that are regularly supplied by Specialty Pharmacy Providers.

6. Drugs that are otherwise defined in the Drug List.

Specialty Pharmacy Program
Program(s) created and/or administered by the Network Manager or by one or more of Our Specialty Pharmacy Providers in order to effectively manage the distribution of Specialty Pharmaceuticals and treatment, services and supplies related to such drugs. These programs will include, but are not limited to, pre-authorization requirements, patient and pharmacy audits, ongoing review for continued Medical Necessity and supply limitations of 7 days for the first treatment under the program and 30 days for subsequent treatments, or as otherwise authorized by the Medical Review Manager.

Specialty Pharmacy Provider
A Pharmacy under contract with the Network Manager to distribute specific Specialty Pharmaceuticals to the Covered Person for self-administration.

Specialty Pharmacy Network
A Prescription Drug delivery system for Specialty Pharmaceuticals in which Specialty Pharmacy Providers are under contract with the Network Manager. The list of Specialty Pharmacy Providers is subject to change at any time without notice.

Stabilize or Stabilized
With respect to a medical condition requiring Emergency Treatment or Emergency Confinement, such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility (or, with respect to a pregnant woman, to deliver, including the placenta).

Speech Therapy
The treatment of a Sickness or an Injury by a Health Care Practitioner who is a speech therapist, using rehabilitative techniques to improve function for voice, speech, language and swallowing disorders.

Subacute Medical Care
A short-term comprehensive Inpatient program of care for a Covered Person who has a Sickness or an Injury that:

1. Does not require the Covered Person to have a prior admission as an Inpatient in a licensed medical facility; and

2. Does not require intensive diagnostic and/or invasive procedures; and

3. Requires Health Care Practitioner direction, intensive nursing care, significant use of ancillaries, and an outcome-focused, interdisciplinary approach using a professional medical team to deliver complex clinical interventions.

Subacute Rehabilitation Facility
A facility that provides Subacute Medical Care for Rehabilitative Services for a Sickness or an Injury on an Inpatient basis. This type of facility must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by one of the following: The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA), or Commission on Accreditation of Rehabilitation Facilities (CARF) to provide Subacute Medical Care for Rehabilitative Services.

2. Be staffed by an on call physician 24 hours per day.

3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.

Not primarily provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same physical facility. The facility may also provide extended care or Custodial Care which would not be covered under this Plan.

Substance Abuse
Abuse of, addiction to, or dependence on drugs, chemicals or alcohol as defined in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by the Plan.

Surgical Assistant
A Health Care Practitioner who is licensed to assist at surgery in the state and credentialed at the facility where the procedure is performed but who is not qualified by licensure, training and credentialing to perform the procedure as a primary surgeon at that facility.

Telehealth
The delivery of health care by a Health Care Practitioner at one location to a patient at a different location via the use of electronic information and telecommunications technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a Covered Person (virtual visit). Telehealth services are provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology.

A communication between a Health Care Practitioner and a patient that consists solely of electronic mail (email) or a facsimile transmission is not considered Telehealth. A communication between licensed Health Care Practitioners that consists solely of a telephone conversation, an email, or a facsimile transmission is not a Telehealth service.

Temporomandibular Joint (TMJ) Dysfunction and Craniomandibular Joint (CMJ) Dysfunction

TMJ Dysfunction and CMJ Dysfunction is any joint disorder of the jaw causing:

1. Clicking and/or difficulties in opening and closing the mouth.

2. Pain or swelling.

3. Complications including arthritis, dislocation and bite problems of the jaw.

Total Disability/Totally Disabled
You or Your spouse is unable to perform the essential duties of any occupation for which reasonably fitted by education, training or experience, whether performed for financial gain or not. Retired individuals and homemakers shall not be considered unable to perform an occupation solely because they are unemployed. A Covered Dependent is Totally Disabled only if confined as a patient in a Hospital or Behavioral Health Facility.

Traditional Drugs
Prescription Drugs on the Drug List, other than Specialty Pharmaceuticals.

Urgent Care
Treatment or services provided for a Sickness or an Injury that:

1. Develops suddenly and unexpectedly outside of a Health Care Practitioner's normal business hours; and

2. Requires immediate treatment, but is not of sufficient severity to be considered Emergency Treatment.

Urgent Care Facility
A facility that is attached to a Hospital, but separate from the Emergency Room, or a separate facility that provides Urgent Care on an Outpatient basis. A Health Care Practitioner's office is not considered to be an Urgent Care Facility, even if services are provided after normal business hours. Room and board and overnight services are not covered. This type of facility must meet all of the following requirements:

1. Be licensed by the state in accordance with the laws for the specific services being provided in that facility.

2. Be staffed by an on duty physician during operating hours.

3. Provide services to stabilize patients who need Emergency Treatment and arrange immediate transportation to an Emergency Room.

4. Provide immediate access to appropriate in-house laboratory and imaging services.

Vori Health Evaluation
The initial assessment for a specific musculoskeletal condition between a Covered Person and a licensed physician, physical therapist, and a health coach via two-way, real-time interactive audio and/or video communication, through the Vori Health® virtual platform.

Vori Health Treatment Plan

A personalized care plan developed by Vori Health for musculoskeletal conditions which meet defined clinical criteria determined by Vori Health providers. Services outlined in the care plan are accessed through the Vori Health virtual platform.

We, Us, Our
These are references to the Plan.

Year
Calendar Year or Plan Year, as described in the Benefit Summary as the Benefit Year Mode.

You, Your, Yours
The Covered Employee.