IMA Financial Group, Inc.

IMA Group Health and Flexible Spending Account Plan
Summary Plan Description

Effective
January 1, 2026

TABLE OF CONTENTS

SECTION I—INTRODUCTION

This document is a description of medical coverage available under the IMA Financial Group Inc. (*Plan*). No oral interpretations can change this *Plan*. The *Plan* described is designed to protect *plan participants* against certain catastrophic health expenses. Terms which have special meanings when used in this *Plan* will be italicized. For a list of these terms and their meanings, please see the **Defined Terms** section of the summary plan description. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

The *employer* fully intends to maintain this *Plan* indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the *Plan* at any time and for any reason.

Changes in the *Plan* may occur in any or all parts of the *Plan* including benefit coverage, *deductibles*, maximums, *co-payments*, exclusions, limitations, defined terms, eligibility, and the like.

This *Plan* is not a 'grandfathered health plan' under the *Patient Protection and Affordable Care Act (PPACA)*, also known as Health Care Reform. Questions regarding the *Plan's* status can be directed to the *Plan Administrator*. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272, or visit **www.dol.gov/ebsa/healthreform**.

Failure to follow the eligibility or enrollment requirements of this *Plan* may result in delay of coverage or no coverage at all. Reimbursement from the *Plan* can be reduced or denied because of certain provisions in the *Plan*, such as coordination of benefits, subrogation, exclusions, timeliness of Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) elections, utilization review or other cost management requirements, lack of *medical necessity*, lack of timely filing of *claims*, or lack of coverage. These provisions are explained in summary fashion in this document. Additional information is available from the *Plan Administrator* at no extra cost.

Read your benefit materials carefully. Before you receive any services, you need to understand what is covered and excluded under your benefit *Plan*, your cost sharing obligations, and the steps you can take to minimize your out-of-pocket costs. For complete terms of the *Plan* and information about benefits which are not outlined in this summary plan description, refer to your *Plan's* wrap document, which can be obtained from your Human Resources representative. If there is any conflict between this summary plan description and the *Plan's* wrap document, this summary plan description will control for benefit-related language and the wrap document will control for language not related to benefits, unless otherwise specified.

Review your *Explanation of Benefits* (*EOB*) forms, other *claim* related information, and available *claims* history. *Notify* the *Third Party Administrator* of any discrepancies or inconsistencies between amounts shown and amounts you actually paid.

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

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

If the *Plan* is terminated or amended, or if benefits are eliminated, the rights of *plan participants* are limited to *covered charges incurred* before termination, amendment, or elimination.

A *plan participant* should contact the *Plan Administrator* to obtain additional information, free of charge, about *Plan* coverage of a specific benefit, particular drug, treatment, test, or any other aspect of *Plan* benefits or requirements. Refer to the Quick Reference Information Chart for contact information.

A. Quick Reference Information Chart

When you need information, please check this document first. If you need further help, call the appropriate phone number listed in the following Quick Reference Information Chart:

QUICK REFERENCE INFORMATION	
Information Needed	**Whom to Contact**
Plan Administrator • Voluntary *Appeals* of *Post-Service Claims*	IMA Financial Group, Inc. 430 E. Douglas, Suite 400 Wichita, KS 67202 1-720-388-1060
Medical Claims Administrator/Third Party Administrator (Medical and Dialysis) • *Claim* Forms (Medical) • Medical *Claims* • First and Second-Level *Appeals* of *Post-Service Claims* • Eligibility for Coverage • Plan Benefit Information	AmeriBen P.O. Box 7186 Boise, ID 83707 1-877-379-4835 **engage.ameriben.com**
Medical Management Administrator • *Pre-Certification*, Concurrent Review, and Case Management • First and Second-Level *Appeals* of *Pre-Service Claims*	AmeriBen Medical Management P.O. Box 7186 Boise, ID 83707 1-888-235-3813
PPO Provider Network Names of *Physicians* & *Hospitals* • Network Provider Directory – see website	Anthem 1-877-379-4835 **www.anthem.com**
Pharmacy Benefits Manager • Retail *Network Pharmacies* • Mail Order (Home Delivery) *Pharmacy* • *Prescription Drug* Information & *Formulary* • Preauthorization of Certain Drugs • Reimbursement for *Non-Network* Retail *Pharmacy* Use • Specialty Pharmacy Program	**Retail** Please refer to the *Plan's* wrap document for the pharmacy vendor name and customer care phone number. **www.caremark.com** **Specialty** CVS/Caremark Specialty Pharmacy 1-800-237-2767 **www.CVSspecialty.com**
Employee Assistance Program (EAP) • EAP Counseling and Referral Services • Mental Health and Well-Being Support • Mindfulness & Sleep Programs • Mental Health Coaching • Critical Incident Support • Work-Life Services • Global Services	Please refer to the *Plan's* wrap document for the EAP vendor name and customer care phone number. Website: **Work.headspace.com** or **helpwhereyouare.com** Company Code: IMA
HSA • HSA	Please refer to the *Plan's* wrap document for the HSA vendor name and customer care phone number. **Healthequity.com**

QUICK REFERENCE INFORMATION (continued)	
Information Needed	**Whom to Contact**
COBRA Administrator • Continuation Coverage	WEX 1-866-451-3399 **cobralogin.wexhealth.com** Please also refer to the *Plan's* wrap document.
Maternal Health Program	Baby Steps 1-888-235-3813 **engage.ameriben.com**
Surgical Care • Care Advocates • Concierge Services for Planned Procedures • Specialty Care Platform	Lantern 1-855-413-7196 **Lanterncare.com**
Musculoskeletal System Treatment • Non-Surgical Regenerative Orthopedics	Regenexx 1-866-494-0623 **Regenexxbenefits.com/imacorp**
Reproductive Health Education and Support • Fertility & Family Building • Maternity & Newborn Care • Menopause • Ongoing Care	Maven Email: support@mavenclinic.com **mavenclinic.com/join/takecare**
Human Resources Information System (HRIS) • Employee Self-Service • Human Resources (HR) Task Management • HR/Employee Data Management • Administrative Task Assistance • Benefits Administration • Payroll Processing • Time and Attendance Management • Reporting & Analytics	UKG/Plansource

B. Plan is Not an Employment Contract

The *Plan* is not to be construed as a contract for or of employment.

C. Plan Administrator

Please refer to the *Plan's* wrap document.

D. Duties of the Plan Administrator

The duties of the *Plan Administrator* are to:

1. administer the *Plan* in accordance with its terms
2. interpret the *Plan*, including the right to remedy possible ambiguities, inconsistencies, or omissions
3. decide disputes that may arise relative to a *plan participant's* rights
4. prescribe procedures for filing a *claim* for benefits and to review *claim* denials
5. keep and maintain the plan documents and all other records pertaining to the *Plan*
6. appoint a *Third Party Administrator* to pay *claims*
7. perform all necessary reporting as required by ERISA

8. establish and communicate procedures to determine whether a *Medical Child Support Order* is qualified under ERISA Sec. 609
9. delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate

E. Amending and Terminating the Plan

The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, as the settlor of the *Plan*, the *Plan Sponsor*, through its directors and officers, may, in its sole discretion, at any time, amend, suspend, or terminate the *Plan* in whole or in part. This includes amending the benefits under the *Plan* or the Trust Agreement (if any).

Any such amendment, suspension, or termination shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which shall be acted upon as provided in the *Plan Sponsor's* Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. *Notice* shall be provided as required by ERISA.

If the *Plan Sponsor* is a different type of entity, then such amendment, suspension, or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the *Plan Sponsor* is a sole proprietorship, then such action shall be taken by the sole proprietor, in their own discretion.

If the *Plan* is terminated, the rights of the *plan participant* are limited to expenses *incurred* before termination. All amendments to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

F. Plan Administrator Compensation

The *Plan Administrator* serves without compensation; however, all expenses for *Plan* administration, including compensation for hired services, will be paid by the *Plan*.

G. Type of Administration

The *Plan* is a self-funded group health plan, and the *claims* administration is provided through a *Third Party Administrator*. The *Plan* is not insured.

H. Employer Information

The *employer's* legal name, address, telephone number, and federal Employer Identification Number are:

IMA Financial Group, Inc.
430 E. Douglas, Suite 400
Wichita, KS 67202
1-720-388-1060
Please refer to the *Plan's* wrap document for the EIN.

I. Plan Name

Please refer to the *Plan's* wrap document.

J. Plan Number

Please refer to the *Plan's* wrap document.

K. Type of Plan

The *Plan* is commonly known as an employee welfare benefit plan. The *Plan* has been adopted to provide *plan participants* certain benefits as described in this document. The IMA Group Health and Flexible Spending Account Plan is to be administered by the *Plan Administrator* in accordance with the provisions of ERISA Section 4(a).

L. Plan Year

The *plan year* is the twelve (12) month period beginning January 1 and ending December 31.

M. Plan Effective Date

January 1, 2026

N. Plan Sponsor

Please refer to the *Plan's* wrap document.

O. Third Party Administrator

The *Plan Administrator* has contracted with a *Third Party Administrator* (*TPA*) to assist the *Plan Administrator* with *claims* adjudication. The *TPA's* name, address, and telephone number are:

AmeriBen
P.O. Box 7186
Boise, ID 83707
1-877-379-4835

A *Third Party Administrator* is **not** a *fiduciary* under the *Plan*, except to the extent otherwise agreed upon in writing or as required under ERISA.

P. Employer's Right to Terminate

Please refer to the *Plan's* wrap document.

Q. Agent for Service of Legal Process

Please refer to the *Plan's* wrap document.

SECTION II—ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

A. Eligibility

Eligible Classes of Employees

All *active employees* of the *employer* working an average of 20 or more hours per week. Please refer to the *Plan's* wrap document for more information.

Eligibility Requirements for Employee Coverage

An eligible retiree who is covered under this *Plan* at the time of retirement will be eligible to continue participating in the *Plan* following retirement, provided the individual continues to make the required contribution. See the **Coordination of Benefits** section for more information on how this *Plan* coordinates with Medicare coverage.

Eligible retirees may continue coverage under this *Plan* until they reach age sixty-five (65) or Medicare eligibility.

An eligible spouse of a retiree may continue coverage under this *Plan* following the retiree's retirement until they reach age sixty-five (65) or Medicare eligibility. No *dependent* child of an eligible retiree may continue coverage under this *Plan* following the retirement or other termination of employment of the retiree, except as provided by COBRA.

The following are excluded from participation:

1. Leased *employees*.
2. Independent contractors as defined in this *Plan*.
3. Consultants who are paid on other than a regular wage or salary basis by the *employer*.
4. Members of the *employer's* Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business and regularly works twenty (20) or more hours per week.

For purposes of this *Plan*, eligibility requirements are used only to determine a person's initial eligibility for coverage under this *Plan*. An *employee* may retain eligibility for coverage under this *Plan* if the *employee* is temporarily absent on an approved leave of absence, which may be combined with the *employer's* short-term disability policy, with the expectation of returning to work following the approved leave as determined by the *employer's* leave policy. Please also refer to the **Continuation During Periods of Employer-Certified Disability, Leave of Absence, or FMLA** subsection.

Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will be deemed to have met the eligibility requirements for the corresponding coverage period as required by the ACA regulations. The *employer's* classification of an individual is conclusive and binding for purposes of determining eligibility under this *Plan*. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency, or otherwise, without regard to whether or not the *employer* agrees to such reclassification, will change a person's eligibility for benefits.

Note: Eligible *employees* and *dependents* who decline to enroll in this *Plan* must state so in writing. In order to preserve potential special enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for special enrollment. See the Special Enrollment Rights subsection of this *Plan*.

Please also refer to the *Plan's* wrap document.

Effective Date of Employee Coverage

If eligible, a *waiting period* must be completed before coverage becomes effective for an *employee* and their *dependents*. A *waiting period* is a period of time that must pass before an *employee* or *dependent* becomes eligible for coverage under the terms of this *Plan*.

An *employee* is eligible for coverage upon completion of the *waiting period*. The *waiting period* will be the time between the date of hire and the effective date, which is the first of the following month. If an *employee* is hired on the first of the month, the effective date will be on that date.

The start of the *waiting period* is the first full day of employment for the job that made the *employee* eligible for coverage under this *Plan*.

Please also refer to the *Plan's* wrap document.

Active Employee Requirement

An *employee* must be an active *employee* (as defined by this *Plan*) for this coverage to take effect.

Eligible Classes of Dependents

A *dependent* is any of the following persons:

1. a covered *employee's* spouse

   The term 'spouse' shall mean the person recognized as the covered *employee's* legally married husband or wife and does include common law marriages. The *Plan Administrator* may require documentation proving a legal marital relationship.

   The term 'spouse' shall also mean the person who is registered with the *employer* as the domestic partner of the *employee*; this includes opposite sex and same sex couples. An individual is a domestic partner of an *employee* if that individual and the *employee* meet each of the following requirements:

   a. The *employee* and individual are eighteen (18) years of age or older and are mentally competent to enter into a legally binding contract.

   b. The *employee* and the individual are not married to anyone.

   c. The *employee* and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

   d. The *employee* and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other, and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least twelve (12) consecutive months and be continuing during the period that the applicable benefit is provided. The *employee* and the individual must have the intention that their relationship will be indefinite.

   e. The *employee* and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence, or similar type of ownership.

   To obtain more detailed information or to apply for this benefit, the *employee* must contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

   In the event the domestic partnership is terminated, either partner is required to inform IMA Financial Group, Inc. of the termination of the partnership.

2. a covered *employee's* child(ren)

   For the purposes of the *Plan*, an *employee's* child includes their:

   a. natural child or stepchild

   b. adopted child or a child placed with the *employee* for adoption

   c. lawfully placed *foster child* for whom health coverage is not provided by the state

   d. spouse's child

   Unless otherwise specified, an *employee's* child will be an eligible *dependent* until reaching the limiting age of twenty-six (26), without regard to student status, marital status, financial dependency, or residency status with the *employee* or any other person. To determine when coverage will end for a child who reaches the applicable limiting age, please refer to the When Dependent Coverage Terminates subsection.

   The phrase 'placed for adoption' refers to a child whom a person intends to adopt, whether or not the adoption has become final, and who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term 'placed' means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption, and the legal process must have commenced.

3. a covered *employee's* qualified *dependents*

   The term 'qualified *dependents'* shall include children for whom the *employee* is a *legal guardian*. The term 'qualified *dependents'* shall include the natural, adopted, or *foster children* of the *employee's* domestic partner or common law spouse. To be eligible for *dependent* coverage under the *Plan*, a qualified *dependent*

must be under the limiting age as described herein. To determine when coverage will end for a qualified *dependent* who reaches the applicable limiting age, please refer to the When Dependent Coverage Terminates subsection.

Any child of a *plan participant* who is an *alternate recipient* under a *Qualified Medical Child Support Order* (*QMCSO*) or National Medical Support Notice shall be considered as having a right to *dependent* coverage under this *Plan*.

A *participant* of this *Plan* may obtain, without charge, a copy of the procedures governing *QMCSO* determinations from the *Plan Administrator*.

The *Plan Administrator* may require documentation proving eligibility for *dependent* coverage, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

4. *Dependent* children over the limiting age may enroll in the *Plan* provided the dependent:
    a. became *totally disabled* prior to age twenty-six (26)
    b. is claimed as a dependent on the *employee's* federal income tax return
    c. is unmarried
    d. is incapable of self-sustaining employment by reason of mental or physical disability
    e. is primarily dependent upon the covered *employee* for support and maintenance

    The *Plan Administrator* may require, at reasonable intervals, continuing proof of the *total disability* and dependency.

    The *Plan Administrator* reserves the right to have such *dependent* examined by a *physician* of the *Plan Administrator's* choice, at the *Plan's* expense, to determine the existence of such incapacity.

Effective Date of Dependent Coverage

A *dependent's* coverage will take effect on the day that the eligibility requirements are met, the *employee* is covered under the *Plan*, and all enrollment requirements are met.

Acquisition of a New Company

When enrollment requirements are met, coverage for eligible *employees* and their eligible *dependents* who are employed by the newly acquired company will be effective as of the date of the acquisition, or the date of termination of the selling company's coverage, whichever is later. The employment *waiting period* will be waived if approved by the *Plan Administrator* in advance or as outlined in the acquisition agreement.

Transitional Care for a Plan Participant upon Acquisition

If a *plan participant's* hospitals, *physicians*, and other health care providers, which were called *network* providers of the selling company's coverage, are no longer a *network* provider under this *Plan* coverage may continue for up to six (6) months for treatment in progress for a *plan participant* who is:

1. In their second or third trimester of pregnancy
2. Receiving care for end-stage renal disease and dialysis
3. Receiving outpatient mental health treatment
4. Terminally ill, with an anticipated life expectancy of six (6) months or less
5. Undergoing an active course of treatment for which changing to a different provider would be likely to cause significant risk of harm to the plan participant's health
6. Undergoing chemotherapy or radiation therapy for treatment of cancer
7. A candidate for a solid organ or bone marrow transplant

The *Claims Administrator* may require documentation proving treatment in progress.

Please also refer to the **Medical Network Information** section, Special Reimbursement subsection, Transition of Care item.

Ineligible Dependent(s)

Unless otherwise provided in this summary plan description, the following are not considered eligible *dependents*:

1. other individuals living in the covered *employee's* home, but who are not eligible as defined

2. the legally separated or divorced former spouse of the *employee*
3. any person who is on active duty in any military service of any country
4. a person who is covered as an *employee* under the *Plan*
5. any other person not defined above in the subsection entitled Eligible Classes of Dependents

Restrictions on Elections

If a *plan participant* changes status from *employee* to *dependent* or *dependent* to *employee*, and the person is covered continuously under this *Plan* before, during, and after the change in status, credit will be given for *deductibles,* and all amounts will be applied to maximums.

If both spouses or domestic partners are *employees*, their children will be covered as *dependents* of one (1) *employee*, but not of both.

If two (2) *employees* (spouses or domestic partners) are covered under the *Plan,* and the *employee* who is covering the *dependent* children terminates coverage, the *dependent* coverage may be continued by the other covered *employee* with no *waiting period* as long as coverage has been continuous.

Accumulators will transfer if a *dependent* changes from coverage under one (1) parent *employee* to coverage under another parent *employee*.

Eligibility Requirements for Dependent Coverage

A *dependent* of an *employee* will become eligible for *dependent* coverage on the first day that the *employee* is eligible for *employee* coverage and the family member satisfies the requirements for *dependent* coverage.

At any time, the *Plan* may require proof that a spouse, domestic partner, qualified *dependent,* or a child qualifies or continues to qualify as a *dependent* as defined by this *Plan*.

B. Enrollment

Enrollment Requirements

An *employee* must enroll for coverage for themselves and/or their *dependents* by completing the enrollment process along with the appropriate payroll deduction authorization.

Enrollment Requirements for Newborn Children

A newborn child, child placed for adoption, or newly adopted child of a covered *employee* is not automatically enrolled in this *Plan*, even if the covered *employee* has previously elected coverage for other *dependents*. An *employee* must complete an enrollment application within the timeframe shown in the Qualifying Events Chart subsection. Your *claim* for maternity expenses is not considered as *notification* to your *employer* for coverage.

If the newborn child (and mother/covered parent) is not enrolled in this *Plan* on a timely basis, there will be no payment from the *Plan,* and the covered parent will be responsible for all costs. You will also have to wait until the next *open enrollment period* to add the child as a *dependent*.

C. Timely Enrollment

The enrollment will be timely if the completed form is received by the *Plan Administrator* no later than thirty (30) days after the person initially becomes eligible for coverage, or within the timeframe shown in the Qualifying Events Chart subsection for each type of special enrollment period.

Late Enrollment

Please refer to the *Plan's* wrap document.

D. Special Enrollment Rights

Federal law provides special enrollment provisions under some circumstances. If an *employee* is declining enrollment for themselves or their *dependents* (including a spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this *Plan* if there is a loss of eligibility for that other coverage (or if the *employer* stops contributing towards the other coverage). However, a request for enrollment must be made within the

timeframe shown in the Qualifying Events Chart subsection after the coverage ends (or after the *employer* stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, registration of a domestic partnership, adoption, or placement for adoption or foster care, there may be a right to enroll in this *Plan*. However, a request for enrollment must be made within the timeframe shown in the Qualifying Events Chart subsection.

The special enrollment rules are described in more detail below. To request special enrollment or obtain more detailed information of these portability provisions, contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

E. Special Enrollment Periods

The *enrollment date* for anyone who enrolls under a special enrollment period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the *Plan* and the first day of coverage is not treated as a *waiting period*.

Individuals Losing Other Coverage, Creating a Special Enrollment Right

An *employee* or *dependent* who is eligible, but not enrolled in this *Plan*, may enroll if loss of eligibility for coverage meets any of the following conditions:

1. The *employee* or *dependent* was covered under a group health plan or had health insurance coverage at the time coverage under this *Plan* was previously offered to the individual.
2. If required by the *Plan Administrator*, the *employee* stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
3. The coverage of the *employee* or *dependent* who had lost the coverage was under COBRA and the COBRA coverage was exhausted or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because *employer* contributions towards the coverage were terminated.
4. The *employee* or *dependent* requests enrollment in this *Plan* no later than the timeframe shown in the Qualifying Events Chart subsection after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of *employer* contributions, described above.

For purposes of these rules, a loss of eligibility occurs if one (1) of the following occurs:

1. The *employee* or *dependent* has a loss of eligibility due to the *Plan* no longer offering any benefits to a class of similarly situated individuals (e.g., part-time *employees*).
2. The *employee* or *dependent* has a loss of eligibility as a result of legal separation, divorce, cessation of *dependent* status (such as attaining the maximum age to be eligible as a *dependent* child under the *Plan*), death, termination of employment, reduction in the number of hours of employment, or contributions towards the coverage were terminated.
3. The *employee* or *dependent* has a loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual).
4. The *employee* or *dependent* has a loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual.

Covered *employees* or *dependents* will not have a special enrollment right if the loss of other coverage results from either:

1. the *employee's* failure to pay premiums or required contributions
2. the *employee* or *dependent* making a fraudulent *claim* or an intentional misrepresentation of a material fact in connection with the *Plan*

Dependent Beneficiaries

If a *dependent* becomes eligible to enroll and the *employee* is not enrolled, the *employee* must enroll in order for the *dependent* to enroll.

If both of the following criteria are met, then the *dependent* (and if not otherwise enrolled, the *employee* and other eligible *dependents*) may be enrolled under this *Plan*:

1. The *employee* is a *plan participant* under this *Plan* (or has met the *waiting period* applicable to becoming a *plan participant* under this *Plan* and is eligible to be enrolled under this *Plan* but for a failure to enroll during a previous enrollment period).
2. A person becomes a *dependent* of the *employee* through marriage, registration of a domestic partnership, birth, adoption, or placement for adoption or foster care.

In the case of the birth or adoption of a child or placement for foster care, the spouse or domestic partner of the covered *employee* may be enrolled as a *dependent* of the covered *employee* if the spouse is otherwise eligible for coverage. If the *employee* is not enrolled at the time of the event, the *employee* must enroll under this special enrollment period in order for their eligible *dependents* to enroll.

The *dependent* special enrollment period is shown in the Qualifying Events Chart subsection. To be eligible for this special enrollment, the *dependent* and/or *employee* must request enrollment within the timeframe specified in the Qualifying Events Chart subsection.

F. Qualifying Events Chart

This chart is only a summary of some of the permitted health plan changes and is not all-inclusive. Please also refer to the *Plan's* wrap document.

Qualifying Event	Effective Date	Forms and Notification Must be Received Within:	You May Make the Following Changes(s)
Marriage or registration of a domestic partnership	First of the month following the date of the event	thirty (30) days of date of marriage or registration of a domestic partnership Please also refer to the *Plan's* wrap document	Enroll yourself, if applicable Enroll your spouse and other eligible or newly acquired *dependents*
Divorce or annulment	First of the month following the date of the event	thirty (30) days of the date of final divorce decree or annulment	Coverage will terminate for your spouse Enroll yourself and *dependent* child(ren) if you, or they, were previously enrolled in your spouse's plan
Birth of your child	Date of birth	thirty (30) days of date of birth of child Please also refer to the *Plan's* wrap document	Enroll yourself Enroll the newborn child and your spouse
Adoption, placement for adoption, *foster child*, or legal guardianship of a child	Date of event	thirty (30) days of date of adoption, placement for adoption, foster child, or legal guardianship of child Please also refer to the *Plan's* wrap document	Enroll yourself Enroll the newly adopted child and your spouse
A change in employment status from part-time to full-time	First of the month following the date of the event	thirty (30) days of change in status	Enroll yourself, if applicable Enroll your new spouse and other eligible *dependents*
A change in employment status (including a change from one *employment* classification to another, you or your spouse taking a qualified unpaid *leave of absence*, a strike or lockout, or a change in worksite)	First of the month following the date of the event	thirty (30) days of *change in employment status* classification	Enroll yourself, if your employment change results in you being eligible for a new set of benefits Enroll your spouse and other eligible *dependents* Drop health coverage Drop your spouse and other eligible *dependents* from your health coverage

Qualifying Event	Effective Date	Forms and Notification Must be Received Within:	You May Make the Following Changes(s)
Significant change in or cost of your, or your spouse's, health coverage due to spouse's employment, including open enrollment	First of the month following the date of the event	thirty (30) days of effective date of change in coverage	Enroll yourself and other eligible *dependents*
A change in the place of residence of the employee, spouse, or dependent	First of the month following the date of the event	thirty (30) days of effective date of change in coverage	Enroll or drop coverage for yourself, your spouse, or covered *dependent* children
Special requirements relating to the Family and Medical Leave Act	First of the month following the date of the event	thirty (30) days of effective date of change in coverage	Enroll or drop coverage for yourself, your spouse, or covered *dependent* children
Spouse or covered *dependent* obtains coverage in another group health plan	First of the month following the date of the event	thirty (30) days of gain of coverage	Drop coverage for yourself, your spouse, or covered *dependent* children
Loss of other coverage, including COBRA coverage	First of the month following the date of the event	thirty (30) days of the date of loss of coverage	Enroll yourself, your spouse and eligible *dependent* children
Spouse's loss of coverage, including COBRA coverage	First of the month following the date of the event	thirty (30) days of the date of loss of coverage	Enroll your spouse and eligible *dependent* children Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse's plan
Eligibility for government-sponsored plan, such as *Medicare* (excluding the government-sponsored Marketplace)	First of the month following the date of the event	thirty (30) days of eligibility date	Drop coverage for the person who became entitled to *Medicare*, Medicaid, or other eligible coverage
CHIP Special Enrollment – loss of eligibility for coverage under a state Medicaid or CHIP program, or eligibility for state premium assistance under Medicaid or CHIP	First of the month following an approved request for coverage	sixty (60) days of the date determined to be eligible Please also refer to the *Plan's* wrap document	Enroll yourself, if applicable Add the person who lost entitlement to CHIP Drop coverage for the person entitled to CHIP coverage
Qualified Medical Support Order affecting a *dependent* child's coverage	Date listed on the notice	thirty (30) days of order	Enroll yourself, if applicable Enroll the eligible child named on *QMCSO*

G. Termination of Coverage

Rescission of Coverage

The *employer* or *Plan* has the right to rescind any coverage of the *employee* and/or *dependents* for cause, making a fraudulent *claim*, or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the *Plan*. The *employer* or *Plan* may either void coverage for the *employee* and/or covered *dependents* for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the *Plan's* discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the *Plan* will provide at least thirty (30) days' advance written *notice* of such action.

When Employee Coverage Terminates

Coverage under this *Plan* will end on the earliest of:

1. the end of the period for which the last contribution is made if the *plan participants* fails to make any required contribution toward the cost of coverage when due
2. the date this *Plan* is canceled
3. the date coverage for the *employee's* benefit class is canceled

4. the last day of the month in which the *employee* tells the *Plan* to cancel their coverage if the *employee* is voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods
5. the end of the stability period in which the *employee* became a member of a non-covered class, as determined by the *employer*
6. if *employee* is temporarily absent from work due to active military duty, refer to the **Continuation During Periods of Employer-Certified Leave of Absence** subsection and USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994
7. A *plan participant* may remain eligible for a limited time if full-time or part-time work ceases due to *leave of absence*. This continuance will end as follows:
    a. For *leave of absence* only: the end of the month after the maximum of six (6) months from the last full day worked (in the case of a sabbatical/vacation, the date of the disability) during the duration of an approved *leave of absence*. This will be subject to the *plan participant* making the required contributions, if any. If a *plan participant* fails to return to work at the end of an approved *leave of absence*, benefits will be terminated as of the end of the *leave of absence* and if eligible, COBRA would then be offered. An approved *leave of absence* must be evidenced by a written document signed by a representative of the *employer*.
    b. While continued, coverage will be that which was in force on the last day worked as an *employee*.
    c. However, if benefits reduce for others in the class, they will also reduce for the continued *plan participant*.
8. the last day of the month in which employment ends
9. the date a *plan participant* submits a false *claim* or are involved in any other fraudulent act related to this *Plan* or any other group plan

Please also refer to the *Plan's* wrap document.

For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled **Continuation Coverage Rights Under COBRA**.

When Dependent Coverage Terminates

A *dependent's* coverage will terminate on the earliest of these dates (except in certain circumstances, a covered *dependent* may be eligible for COBRA continuation coverage):

1. the date the *Plan* or *dependent* coverage under the *Plan* is terminated
2. the last day of the calendar month that the *employee's* coverage under the *Plan* terminates for any reason, including death
3. the last day of the calendar month a covered spouse loses coverage due to loss of dependency
4. the last day of the calendar month that a person ceases to be a *dependent* as defined by the *Plan*
5. the last day of the calendar month that a *dependent* child ceases to be a *dependent* as defined by the *Plan* due to age as listed in the Eligible Classes of Dependents provisions
6. the date of the covered *dependent's* death
7. the end of the period for which the required contribution has been paid if the charge for the next period is not paid when due

For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled **Continuation Coverage Rights Under COBRA.**

H. Continuation During Periods of Employer-Certified Disability, Leave of Absence, or FMLA

A *plan participant* may remain eligible for a limited time if full-time or part-time work ceases due to *leave of absence*. This continuance will end as follows, for *leave of absence* only:

The end of the month after the maximum of six (6) months from the last full day worked (in the case of a sabbatical / vacation, the date of the disability) during the duration of an approved *leave of absence*. This will be subject to the *plan participant* making the required contributions, if any. If a *plan participant* fails to return to work at the end of an approved *leave of absence*, benefits will be terminated as of the end of the *leave of absence* and if eligible, COBRA

would then be offered. An approved *leave of absence* must be evidenced by a written document signed by a representative of the *employer*. While continued, coverage will be that which was in force on the last day worked as an *employee*. However, if benefits reduce for others in the class, they will also reduce for the continued *plan participant*.

A *plan participant* may remain eligible for a limited time if full-time or part-time work ceases due to *leave of absence*.

This continuance will end as follows:

For *leave of absence* only: the end of the month after the maximum of six (6) months from the last full day worked (in the case of a sabbatical/vacation, the date of the disability) during the duration of an approved *leave of absence*. This will be subject to the *plan participant* making the required contributions, if any. If a *plan participant* fails to return to work at the end of an approved *leave of absence*, benefits will be terminated as of the end of the *leave of absence* and if eligible, COBRA would then be offered. An approved *leave of absence* must be evidenced by a written document signed by a representative of the *employer*.

While continued, coverage will be that which was in force on the last day worked as an *employee*.

However, if benefits reduce for others in the class, they will also reduce for the continued *plan participant*.

Please also refer to the *Plan's* wrap document.

I. Rehiring a Terminated Employee

If a *plan participants* employment is terminated and such *plan participant* is rehired, upon return to active employment such rehired *plan participant* will be subject to the following provisions:

1. If re-employment occurs within thirty (30) days and during the same *plan year*, the *plan participant* will not be allowed to make a new election but will be required to continue the same election in place at the time the *plan participant* terminated employment, subject to recognized changes in status occurring during the *plan participants* absence.

   If re-employment occurs within thirty (30) days but during the following *plan year*, the rehired *plan participant* will be permitted to make a different election than was in place at the time the *plan participant* terminated employment and will be immediately eligible for coverages offered under the *Plan* (no waiting period will apply).

   If the rehired *plan participant* elects to resume or commence coverage, or if coverage resumes automatically, coverage will resume or commence as of the first day of the calendar month immediately following the return to service.
2. If re-employment occurs after thirty (30) days but within ninety-one (91) days, the rehired *plan participant* will be permitted to make a different election than was in place at the time the *plan participants* terminated employment and will be immediately eligible for coverages offered under the *Plan* (no waiting period will apply). If the rehired *plan participant* elects to resume or commence coverage, coverage will resume or commence as of the first day of the calendar month immediately following the return to service.
3. If re-employment occurs after ninety-one (91) days, upon return to active employment such rehired *plan participant* will be treated as a new *employee* of the *employer* and permitted to enter into a new election after again satisfying the eligibility requirements including any applicable waiting period.

Please also refer to the *Plan's* wrap document.

J. Open Enrollment

During the annual open enrollment period, eligible *employees* and retirees will be able to enroll themselves and their eligible *dependents* for coverage under this *Plan*. *Plan participants* and covered retirees will be able to make changes in coverage for themselves and their eligible *dependents*.

Coverage waiting periods are waived during the annual open enrollment period for covered *employees*, covered retirees, and covered *dependents* changing from one plan to another plan or changing coverage levels within the *Plan*.

The annual open enrollment does not apply to retirees or their *dependents*.

If you and/or your *dependent* become covered under this *Plan* as a result of electing coverage during the annual open enrollment period, the following will apply:

1. the *employer* will give eligible *employees* written notice prior to the start of an annual open enrollment period
2. this *Plan* does not apply to charges for services performed or treatment received prior to the effective date of the *plan participant's* coverage
3. the effective date of coverage will be January 1 following the annual open enrollment period

Please also refer to the *Plan's* wrap document.

SECTION III—CONSOLIDATED APPROPRIATIONS ACT OF 2021 AND TRANSPARENCY IN COVERAGE REGULATIONS

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act. In addition, the Transparency in Coverage (TIC) regulations contain transparency requirements. Portions of the CAA and TIC are described briefly below. Enforcement dates, standards for implementation, coordination with other entities, legal developments, and updates offered by federal and/or state entities directly impact actions and availability of the items described. In addition, some plan types are not subject to the CAA and/or TIC, or certain provisions of either.

A. Surprise Billing Claims

Surprise billing claims are claims that are subject to the No Surprises Billing Act requirements. These are:

1. *emergency services* in an emergency department of a hospital or independent freestanding emergency department provided by *non-network* providers or facility
2. services provided by a *non-network* provider at a *network* facility
3. *non-network* air ambulance services

The section below contains further information about how these *claim* categories apply to your *Plan* and are dependent on covered benefits.

B. No Surprises Billing Act Requirements

Emergency Services

As required by the CAA, *emergency services* are covered under your *Plan*:

1. without the need for *pre-certification*
2. whether the provider is *network* or *non-network*

If the *emergency services* you receive in an emergency department of a hospital or independent freestanding emergency department are provided by a *non-network* provider or facility, covered services will be processed at the *network* benefit level in accordance with the CAA.

Note that if you receive *emergency services* from a *non-network* provider or facility, your out-of-pocket costs will be limited to amounts that would apply if the covered services had been furnished by a *network* provider or facility. However, *non-network cost-sharing amounts* (i.e., *co-payments*, *deductibles*, and/or *co-insurance*) will apply to your *claim* if the treating *non-network* provider or facility determines you are stable and the *non-network* provider satisfies all of the following requirements:

1. determines that you are able to travel to a *network* facility by non-emergency or non-medical transport to an available *network* provider or facility within a reasonable distance based on your condition
2. complies with the *notice* and consent requirement
3. determines that you are in condition to receive the information and provide informed consent

If you continue to receive services from the *non-network* provider after you are stabilized, you will be responsible for the *non-network cost-sharing amounts*, and the *non-network* provider will also be able to charge you any difference between the *maximum allowable amount* and the *non-network* provider's billed charges.

Non-Network Services Provided at a Network Facility

When you receive covered services from a *non-network* provider at a *network* facility, your *claims* will be paid at the *non-network* benefit level if the *non-network* provider gives you proper *notice* of its charges, and you give written consent to such charges. This means you will be responsible for *non-network cost-sharing amounts* for those services and the *non-network* provider can also charge you any difference between the *maximum allowable amount* and the *non-network* provider's billed charges.

This requirement does not apply to ancillary services. Ancillary services are defined as:

1. items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a *physician* or non-physician practitioner
2. items and services provided by assistant surgeons, hospitalists, and intensivists

3. diagnostic services, including radiology and laboratory services
4. items and services provided by a *non-participating provider* if there is no *participating provider* who can furnish such item or service at such facility

This *notice* and consent exception also does not apply if the covered services furnished by a *non-network* provider result from unforeseen and urgent medical needs arising at the time of service.

Non-network providers satisfy the *notice* and consent requirement by one (1) of the following:

1. by obtaining your consent and offering the required notice no later than seventy-two (72) hours prior to the delivery of services
2. the *notice* is given and consent is obtained on the date of the service, if you make an appointment within seventy-two (72) hours of the services being delivered

To help you determine whether a provider is *non-network*, the *network* is required to confirm the list of *network* providers in its provider directory every ninety (90) days. If you can show that you received inaccurate information from the *network* that a provider was *in-network* on a particular *claim*, then you will only be liable for *network cost sharing amounts* (i.e., *co-payments*, *deductibles*, and/or *co-insurance*) for that *claim*. Your *network cost-sharing amount* will be calculated based upon the *maximum allowed amount*. In addition to your *network* cost-share, the *non-network* provider can also charge you for the difference between the *maximum allowed amount* and their billed charges.

C. How Cost-Shares Are Calculated

Your *cost sharing amounts* for emergency services in an emergency department of a hospital or independent freestanding emergency department or for covered services received by a *non-network* provider at a *network* facility will be calculated as defined by the CAA, such as the lesser of billed charges or the median plan *network* contract rate (called the Qualifying Paying Amount or QPA) that we pay *network* providers for the geographic area where the covered service is provided if other calculation criteria does not apply. Any out-of-pocket cost you pay to a *non-network* provider for either these *emergency services* or for covered services provided by a *non-network* provider at a *network* facility will be applied to your *network out-of-pocket limit*. Cost-sharing for air ambulance services is based on the lesser of billed charges or the QPA.

D. Appeals

If you receive *emergency services* in an emergency department of a hospital or independent freestanding emergency department from a *non-network* provider, covered services from a *non-network* provider at a *network* facility, or *non-network* air ambulance services and believe those services are covered by your Plan's benefits and the No Surprise Billing Act, you have the right to appeal that *claim*. If your appeal of a *surprise billing claim* is denied, then you have a right to appeal the adverse decision to an independent review organization as set out in the **Claims and Appeals** section of this summary plan description. A provider can dispute the payment they received from the *Plan* by utilizing a process set up by the CAA, or if applicable, state law. The CAA process includes Open Negotiation, and if unresolved, Independent Dispute Resolution. Importantly, this process does not include the *plan participant*, and you are not required to participate. To learn more about the CAA, you can visit **https://www.cms.gov/nosurprises**.

E. Transparency Requirements

Under your *Plan*, the following are provided as required by the CAA and/or TIC. Depending on how the *Plan* interacts with other entities, these may be provided from the *Third Party Administrator*, the *network*, Pharmacy Benefit Manager, and/or other stakeholders (ex. Customer Care or Member Services):

1. protections with respect to *surprise billing claims* by providers
2. estimates on what *non-network* providers may charge for a particular service
3. information on contacting state and federal agencies in case you believe a provider has violated the No Surprise Billing Act's requirements

When asked, a paper copy of the type of information you request from the above list can be provided.

Through the price comparison/shoppable services estimate tool(s) associated with your *Plan* or through Member Services at the phone number on the back of your ID card, you can receive the following:

1. cost sharing information that you may be responsible for, for a service from a specific *network* provider

2. a list of all *network* providers
3. cost sharing information on *non-network* providers' services based on what you may pay *non-network* providers for the service

As applicable, under machine readable requirements from the TIC, the *network*, Pharmacy Benefit Manager, *Third Party Administrator*, and/or entities associated with your *Plan* will provide access through separate publicly accessible websites that contain the following information:

1. *network* negotiated rates
2. historical *non-network* allowed amounts
3. drug pricing information

F. Continuity of Care

If a *network* provider leaves the *network* for any reason other than termination for failure to meet applicable quality standards, fraud, or otherwise defined by the CAA, you may be able to continue seeing that provider for a limited period of time and still receive *network* benefits. The CAA permits you to request and decide to continue to have benefits provided under the same terms and conditions as you would have had under the Plan had the provider not moved to *non-network* status. If authorized, continuity of care ends ninety (90) days after you are notified by the *Plan* or its delegate of the right to request continuity of care or the date you are no longer under care of the provider, whichever of these is earlier.

Continuity of care under the CAA is permitted for a *plan participant* who, with respect to a provider, qualifies based on any of the following circumstances:

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility
2. is undergoing a course of institutional or inpatient care from the provider or facility
3. is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility

Under the CAA, the term 'serious and complex condition' means, with respect to a *participant*, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage, one (1) of the following:

1. in the case of an acute *illness*, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm
2. in the case of a chronic *illness* or condition, a condition that satisfies both of the following criteria:
    a. is life-threatening, degenerative, potentially disabling, or congenital
    b. requires specialized medical care over a prolonged period of time

If you wish to continue seeing the same provider/facility and you believe continuity of care under the CAA applies, you or your provider/facility should contact the entity responsible for Member Services on back of your card for how to apply for continuity of care.

SECTION IV—MEDICAL NETWORK INFORMATION

A. Network and Non-Network Services

Network Provider Information

The *Plan* has entered into an agreement with a medical *network* that maintains contractual agreements with certain *hospitals*, *physicians*, and other health care providers which are called *network* providers. Because these *network* providers have agreed to charge reduced fees to persons covered under the *Plan*, the *Plan* can afford to reimburse a higher percentage of their fees.

Therefore, when a *plan participant* uses a *network* provider, that *plan participant* will receive better benefits from the *Plan* than when a *non-network* provider is used. It is the *plan participant's* choice as to which provider to use.

Non-Network Provider Information

Non-network providers have no agreements with the *Plan* or the *Plan's* medical *network* and are generally free to set their own charges for the services or supplies they provide. The *Plan* will reimburse for the *allowable charges* for any *medically necessary* services or supplies, subject to the *Plan's deductibles*, *co-insurance*, *co-payments*, limitations, and exclusions. *Plan participants* must submit proof of *claim* before any such reimbursement will be made.

Before you obtain services or supplies from a *non-network* provider, you can find out whether the *Plan* will provide *network* or *non-network* benefits for those services or supplies by contacting the *Third Party Administrator* as outlined in the Quick Reference Information Chart.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

Provider Non-Discrimination

To the extent that an item or service is a *covered charge* under the *Plan*, the terms of the *Plan* shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable state law. This provision does not preclude the *Plan* from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided, and does not require the *Plan* to accept all types of providers as a *network* provider.

B. Choosing a Physician – Patient Protection Notice

The *Plan* does not require you to select a *primary care physician* (*PCP*) to coordinate your care, and you do not have to obtain a referral to see a specialist.

Please also refer to the *Plan's* wrap document for more information.

C. Special Reimbursement Provisions

Under the following circumstances, the higher *network* payment will be made for certain *non-network* services:

1. **Medical Emergency.** In a *medical emergency*, a *plan participant* should try to access a *network* provider for treatment. However, if immediate treatment is required and this is not possible, the services of *non-network* providers will be covered until the *plan participant's* condition has stabilized to the extent that they can be safely transferred to a *network* provider's care. At that point, if the transfer does not take place, *non-network* services will be covered at *non-network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* the *Third Party Administrator* for a review of any *claim* that meets this definition.
2. **No Choice of Provider.** If, while receiving treatment at a *network* facility and provider (other than from a surgeon in a non-emergency situation), a *plan participant* receives ancillary services or supplies from a *non-network* provider in a situation in which they have no control over provider selection (such as in the selection of an ambulance, emergency room *physician*, anesthesiologist, assistant surgeon, or a provider for *diagnostic services*), such *non-network* services or supplies will be covered at *network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* the *Third Party Administrator* for a review of any *claim* that meets this definition.
3. **Providers Outside of Network Area.** If *non-network primary care physicians* or specialists are used because the necessary service or specialty is not in the *network* or is not reasonably accessible to the *plan participant* due to geographic constraints (as dictated by the *Plan*) , such *non-network* service or specialist care will be covered at *network* benefit levels. Charges that meet this definition will be paid based on the *maximum*

allowable charges. The *plan participant* will be responsible for *notifying* the *Third Party Administrator* for a review of any *claim* that meets this definition.

4. **Transition of Care.** If you are currently under the care of a *non-network* provider, transition of care will only be considered for: a second or third trimester pregnancy, post-partum care up to eight (8) weeks, cancer treatment, end-stage renal disease and dialysis, outpatient *mental health*/*substance use* treatment, organ transplant, *inpatient* care in a hospital, post-acute injury or surgery within the past three (3) months, treatment for terminally ill *plan participant* with an anticipated life expectancy of six (6) months or less, or undergoing an active course of treatment for which changing to a different provider would be likely to cause a signification risk of harm to the covered person's health. If transitional care is appropriate, specific treatment by a *non-network* provider may be covered at the *network* level of benefits for ninety (90) days. This provision applies only to *plan participants* who were enrolled in the *Plan* prior to January 1, 2026.

Additional information about this option, as well as a list of *network* providers, will be given to *plan participants*, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

D. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call the *Claims Administrator* to find out Your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up-to-date health Identification Card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core Service Center any time. They are available twenty-four (24) hours a day, seven (7) days a week. The toll free number is 1-800-810-2583. Or you can call them collect at 1-804-673-1177.

If you need *inpatient hospital* care, you or someone on your behalf should contact the *Claims Administrator* for *pre-certification* as outlined in the Quick Reference Information Chart. Keep in mind, if you need emergency medical care, go to the nearest *hospital*. There is no need to call before you receive care.

Please refer to the **Health Care Management Program** *pre-certification* provisions in this booklet for further information. You can learn how to get *pre-certification* when you need to be admitted to the *hospital* for emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core

In most cases, when you arrange *inpatient hospital* care with Blue Cross Blue Shield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any *co-payment*, *co-insurance*, or *deductible* amounts that may apply.

You will typically need to pay for the following services up front:

1. doctor services
2. *inpatient hospital* care not arranged through Blue Cross Blue Shield Global Core
3. *outpatient* services

You will need to file a *claim* form for any payments made up front.

When you need Blue Cross Blue Shield Global Core *claim* forms, you can get international *claims* forms in the following ways:

1. call the Blue Cross Blue Shield Global Core Service Center at the numbers above
2. online at **www.bcbsglobalcore.com** or **engage.ameriben.com**

You will find the address for mailing the *claim* on the form.

E. Network Information

You may obtain more information about the providers in the *network* by contacting the *network* by phone or by visiting their website.

Anthem

1-877-379-4835

www.anthem.com

All locations

SECTION V—SCHEDULE OF BENEFITS

A. Verification of Eligibility: 1-877-379-4835

Call this number to verify eligibility for *Plan* benefits **before** charges are *incurred*. Please note that oral or written communications with the *Third Party Administrator* regarding a *plan participant's* or beneficiary's eligibility or coverage under the *Plan* are not *claims* for benefits, and the information provided by the *Third Party Administrator* or other *Plan* representative in such communications does not constitute a certification of benefits or a guarantee that any particular *claim* will be paid. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this summary plan description.

B. Schedule of Benefits

All benefits described in the **Schedule of Benefits** are subject to the exclusions and limitations described more fully herein, including, but not limited to, the *Plan Administrator's* determination that care and treatment is *medically necessary*; those charges are in accordance with the *maximum allowable charge*; and that services, supplies, and care are not *experimental/investigational*.

This document is intended to describe the benefits provided under the *Plan,* but due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all *covered charges* and/or exclusions with specificity. If you have questions about specific supplies, treatments, or procedures, please contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

The *Plan Administrator* retains the right to audit *claims* to identify treatment(s) that are, or were, not *medically necessary*, *experimental*, *investigational*, or not in accordance with the *maximum allowable charges*.

C. Deductible Amount

Deductibles are dollar amounts that the *plan participant* must pay before the *Plan* pays. Before benefits can be paid in a *benefit year,* a *plan participant* must meet the *deductible* shown in the applicable Schedule of Medical Benefits.

This amount will accrue toward the 100% maximum *out-of-pocket limit*.

D. Benefit Payment

Each *calendar year*, benefits will be paid for the *covered charges* of a *plan participant* that are in excess of the *deductible*, any *co-payments*, and any amounts paid for the same services. Payment will be made at the rate shown under the reimbursement rate in the applicable Schedule of Medical Benefits. No benefits will be paid in excess of the *maximum benefit* amount or any listed limit of the *Plan*.

All dollar and visit limits are combined for *network* and *non-network* services, unless otherwise noted.

Services rendered may have professional, facility, and other components for which *physicians* and facilities may bill separately.

E. Out-of-Pocket Limit

Covered charges are payable at the percentages shown each *calendar year* until the *out-of-pocket limit* shown in the applicable Schedule of Medical Benefits is reached. Then, *covered charges incurred* by a *plan participant* will be payable at 100% (except for the charges excluded) for the remainder of the *calendar year*.

F. Diagnosis Related Grouping (DRG)

Diagnosis related grouping (*DRG*) is a method for reimbursing *hospitals* for *inpatient* services. This is when a provider bills for services that go together in a group, or bundle, instead of the individual services that make up the group separately. The provider has agreed to a set *DRG* rate with the *network*. When a service is rendered, regardless of what the provider bills, the *DRG* amount has already been set for that specific group of services. A *DRG* amount can be higher or lower than the actual billed charge because it is based on an average cost for the services rendered.

In the case where the *DRG* amount on an eligible *claim* is higher than the actual billed charges, the following will determine how each party's cost sharing will be determined:

1. the *Plan* will base their portion of the charge on the *network allowed amount*
2. the *plan participant's* portion of the charge will be based on the billed charges
3. the difference in the *network allowed amount* versus the actual billed charges will be the responsibility of the *Plan*

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

G. Co-Insurance

For *covered charges incurred* with a *network* provider, the *Plan* and/or *plan participant* pays a specified percentage of the negotiated rate. This percentage varies, depending on the type of *covered charge*, and is specified in the applicable Schedule of Medical Benefits. You are responsible for the difference between the percentage the *Plan* pays and 100% of the negotiated rate.

For *covered charges incurred* with a *non-network* provider, the *Plan* pays a specified percentage of *covered charges* at the *maximum allowable charge*. In those circumstances, you are responsible for the difference between the percentage the *Plan* pays and 100% of the billed amount, unless your *claim* is a *surprise billing claim*.

These amounts for which you are responsible are known as *co-insurance*. Unless noted otherwise in the Special Comments column of the applicable Schedule of Medical Benefits, your *co-insurance* applies towards satisfaction of the *out-of-pocket limit*.

H. Co-Payments

In certain cases, instead of paying *co-insurance*, you must pay a specific dollar amount, as specified in the applicable Schedule of Medical Benefits. This amount for which you are responsible is known as a *co-payment* and is typically payable to the health care provider at the time services or supplies are rendered.

Unless otherwise stated in the applicable Schedule of Medical Benefits, *co-payments* are applied per provider per day.

Unless noted otherwise in the Special Comments column of the applicable Schedule of Medical Benefits, your *co-payments* apply toward satisfaction of the *out-of-pocket limit*.

I. Balance Bill

The *balance bill* refers to the amount you may be charged for the difference between a *non-network* provider's billed charges and the *allowable charge*.

Network providers will accept the *allowable charge* for *covered charges*. They will not charge you for the difference between their billed charges and the *allowable charge*.

Non-network providers have no obligation to accept the *allowable charge*. You are responsible to pay a *non-network* provider's billed charges, even though reimbursement is based on the *allowable charge*. Depending on what billing arrangements you make with a *non-network* provider, the provider may charge you for full billed charges at the time of service or seek to *balance bill* you for the difference between billed charges and the amount that is reimbursed on a *claim*.

Any amounts paid for *balance bills* do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

Refer to the **Prescription Drug Benefits** section of this summary plan description for additional information on *prescription drug* coverage.

J. Schedule of Medical Benefits – Blue 002 Option

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Calendar Year The *network* and *non-network deductible* amounts do not accumulate towards each other. *Co-payments, prescription drugs,* and *co-insurance* do not apply to the *deductible*.		
Per *plan participant*	$1,000	$2,000
Per *family unit*	$2,000	$4,000
Family Unit - Embedded Deductible If you are enrolled in the family option, your *Plan* contains two (2) components: an individual *deductible* and a *family unit deductible*. Having two (2) components to the *deductible* allows for each member of your *family unit* the opportunity to have your *Plan* cover medical expenses prior to the entire dollar amount of the *family unit deductible* being met. The individual *deductible* is embedded in the family *deductible*. **For example,** if you, your spouse, and child are on a family plan with a $2,000 *family unit* embedded *deductible*, and the individual *deductible* is $1,000, and your child *incurs* $1,000 in medical bills, their *deductible* is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year*, even though the *family unit deductible* of $2,000 has not been met yet.		
Maximum Out-of-Pocket Limit, per Calendar Year The *out-of-pocket limit* includes *co-payments, co-insurance, deductibles,* and covered *prescription drug* charges. The *network* and *non-network out-of-pocket limits* do not accumulate towards each other.		
Per *plan participant*	$4,000	$8,000
Per *family unit*	$8,000	$16,000
Family Unit - Embedded Out-of-Pocket Limit If you are enrolled in the *family unit* option, your *Plan* contains two (2) components: an individual *out-of-pocket limit* and a *family unit out-of-pocket limit*. Having two (2) components to the *out-of-pocket limit* allows each member of your *family unit* the opportunity to have their *covered charges* be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the *family unit out-of-pocket limit* being met. The individual *out-of-pocket limit* is embedded in the *family unit out-of-pocket limit*.		
The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise. **NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the Plan:** 1. cost containment penalties 2. amounts over *the maximum allowable charges* 3. charges not covered under the *Plan* 4. *balance billed* charges		

Benefits shown as *co-payments* are listed for what the *plan participant* will pay.

Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply.
Acupuncture	\$50 *co-payment*, *deductible* waived		**Calendar Year Maximum:** ten (10) visits, combined with massage therapy
Advanced Imaging	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Includes Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans, excluding services rendered in an emergency room setting. ***Pre-certification* is required.**
Allergy Services			
Allergy Testing	80% *co-insurance*, *deductible* waived	50% *co-insurance* after *deductible*	
Allergy Serum & Injections	100% *co-insurance* *deductible* waived	50% *co-insurance* after *deductible*	
Ambulance Service	80% *co-insurance* after *deductible*		***Pre-certification* is required** for non-emergent air ambulance. Please refer to the **Medical Benefits** section, Covered Medical Charges, Ambulance, for a further description and limitations of this benefit.
Chiropractic Treatment	\$50 *co-payment*, *deductible* waived		All services provided during the chiropractic visit will apply to the chiropractic benefit. *Spinal manipulations* apply to the rendering provider's benefit level. **Calendar Year Maximum:** twenty (20) visits
Dental Injury	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Diagnostic Testing	100% *co-insurance*, *deductible* waived	50% *co-insurance* after *deductible*	
Durable Medical Equipment (DME)	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	***Pre-certification* is required** for *DME* in excess of \$3,000 purchase/rental price.
Emergency Room	\$200 *co-payment*, *deductible* waived		The emergency room *co-payment* applies to the facility charges only. The *co-payment* applies per visit. The emergency room *co-payment* is waived if admitted.

002 Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Gender	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Treatment for gender conditions. Refer to the Travel Expenses provision in the Covered Medical Charges for applicable travel benefits.
Hearing			
Hearing Aids	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	**Benefit Maximum:** $2,500 per ear every three (3) years. Batteries do not apply to the maximum.
Hearing Exam (Diagnostic)	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Hearing Exam (Routine)	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Implantable Hearing Devices	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Home Health Care	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	**Calendar Year Maximum:** ninety (90) visits **Intermittent nurse services are limited to one (1) nurse at any one time, not to exceed four (4) hours per twenty-four (24) hour period.** ***Pre-certification* is required.**
Hospice Care	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Infertility Testing and Treatment	100% *co-insurance*, *deductible* waived	100% *co-insurance* *deductible* waived	**Lifetime Maximum:** $20,000. Artificial insemination does not apply to this limit. *Infertility* benefit covers services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an *illness* causing an *infertility* condition when such treatment is performed in an attempt to bring about a pregnancy.
Inpatient Hospital			
Physician Visits	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Room and Board	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	**Limited to the semi-private room rate when such semi-private room rate is available.** ***Pre-certification* is required.**
Lab & X-Ray	80% co-insurance, deductible waived	50% co-insurance after deductible	**Lab and x-ray services billed in an outpatient hospital setting or by an independent lab.**
Massage Therapy	$50 co-payment, deductible waived	50% co-insurance after deductible	**Calendar Year Maximum: ten (10) visits, combined with acupuncture**
Mastectomy Bras/Camisoles	80% co-insurance after deductible	50% co-insurance after deductible	**Calendar Year Maximum: mastectomy bra and camisole purchases up to six (6) total items**

002 Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Maternity			
Non-Routine Services	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Routine Services	100% *co-insurance*, *deductible* waived	50% *co-insurance* after *deductible*	
Mental Disorders & Substance Use Disorder			
Inpatient	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Includes residential treatment facility. ***Pre-certification* is required.**
Office	$25 *co-payment*, *deductible* waived		
Outpatient (Other)	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Includes partial hospitalization and intensive *outpatient* program. ***Pre-certification* is required** for partial hospitalization and intensive *outpatient* program in excess of twenty-five (25) visits per *calendar year* per therapy type.
Morbid Obesity	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Nutritional Counseling/ Therapy	$25 *co-payment*, *deductible* waived		
Office Visit			
Primary Care Physician	$25 *co-payment*, *deductible* waived	50% *co-insurance* after *deductible*	If the *physician's* office is inside a *hospital*, the *co-payment* applies to the office visit only. All other services rendered during the *physician's* office visit in a *hospital* are paid at the applicable benefit level. The *co-payment* applies to the office visit charge only.
Specialist	$50 *co-payment*, *deductible* waived	50% *co-insurance* after *deductible*	
Other Services Provided in an Office	100% *co-insurance*, *deductible* waived	50% *co-insurance* after *deductible*	This benefit applies for all services provides within an office visit, except for the following, which will be paid at the applicable benefit level: independent labs, services billed by radiologist or pathologist including independent radiology facility (freestanding radiology facility), and advanced imaging.
Prosthetics	80% co-insurance after deductible	50% co-insurance after deductible	Pre-certification is required for prosthetics in excess of $3,000 purchase price.
Outpatient Observation Stays	80% co-insurance after deductible	50% co-insurance after deductible	After twenty-three (23) observation hours, a confinement will be considered at this benefit level. Prior to twenty-three (23) observation hours, benefits will pay at the applicable benefit level.
Outpatient Surgery	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	***Pre-certification* is required for certain surgical procedures.** Refer to Health Care Management Program, Pre-Certification for details.

002 Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Rehabilitation Facility	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	**Calendar Year Maximum:** ninety (90) days ***Pre-certification* is required.**
Respiratory Therapy	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Retail Clinic Visits	$25 *co-payment*, *deductible* waived		
Skilled Nursing Facility	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	**Calendar Year Maximum:** ninety (90) days ***Pre-certification* is required.**
Sterilization (Male)	100% *co-insurance*, *deductible* waived	80% *co-insurance* after *deductible*	
Telemedicine			
LiveHealth Online	100% *co-insurance*, *deductible* waived	Not Applicable	Telemedicine benefit provided through Anthem at **www.livehealthonline.com**. Please also refer to the *Plan's* wrap document.
All Other Vendors (Primary Care Physician)	$25 *co-payment*, *deductible* waived	50% *co-insurance* after *deductible*	
All Other Vendors (Specialist)	$50 *co-payment*, *deductible* waived	50% *co-insurance* after *deductible*	
Therapy Services			
Physical Therapy Occupational Therapy Speech Therapy	80% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	***Pre-certification* is required** for physical therapy, occupational therapy, and speech therapy in excess of twenty-five (25) visits per *calendar year* per therapy type.
Travel	100% *co-insurance* after *deductible*	Not Covered	**Adoptive Cell Therapy, Gender Dysphoria, Gene Therapy, and Transplant Benefit Maximum:** $10,000 per *calendar year*, each **Bariatric Surgery and Covered Restrictive Services:** $2,000 per *calendar year*, each Refer to the **Medical Benefits** section for a further description and limitations of this benefit and any associated covered travel expenses.
Urgent Care	$50 *co-payment*, *deductible* waived		The urgent care visit *co-payment* will apply to the urgent care visit and all other services, including lab and x-rays, performed and billed by the *physician* for the same date of service.
Wigs	80% *co-insurance* after *deductible*		Limited to hair loss related to chemotherapy, radiation therapy, burns, alopecia, or behavioral health conditions. **Calendar Year Maximum:** $500. Includes coverage for wigs purchased over the counter.

002 Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), the IRS Safe Harbor preventive services list, or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network* provider at a Routine Wellness Care visit. If there are no *network* providers who perform or provide the service, then *non-network* providers will be covered at the *network* level. For more information about preventive services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations** **www.hrsa.gov** **Safe Harbor Services:** **https://www.irs.gov/pub/irs-drop/n-04-23.pdf** **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** Non-Preventive Care services which are ordered or performed at a Routine Wellness Care visit are not considered under the Preventive Care benefit. Those services will apply to their applicable benefit level or exclusion as appropriate.			
Routine Wellness Care	100% *co-insurance*, *deductible* waived	50% *co-insurance* after *deductible*	Services include routine physical exam, labs and x-rays, immunizations, gynecological exam, pap smear, PSA test, 2D and 3D mammogram, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. **Calendar Year Maximum:** One (1) visit per adult *plan participant*. This maximum does not include the well woman visit. Please refer to the **Medical Benefits** section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Breastfeeding Pump and Supplies	100% *co-insurance*, *deductible* waived		Breastfeeding support and supplies. Breast pumps purchased over the counter will be covered. ***Pre-certification* is required for breastfeeding pumps in excess of $500 purchase/rental price.**
Contraceptive Services	100% *co-insurance*, *deductible* waived	50% *co-insurance* after *deductible*	Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion. **Benefit Limitations:** Services are available to all female *plan participants*.

Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.

K. Schedule of Prescription Drug Benefits – Blue 002 Option

The *prescription drug* benefits are separate from the medical benefits and are administered by CVS through Meritain. Refer to the **Prescription Drug Benefits** section of this summary plan description for additional information on *prescription drug* coverage.

Prescription drug charges do not apply to the medical *deductible*. There is not a *prescription drug deductible*. *Prescription drug* charges do apply to the medical *out-of-pocket* maximum.

Benefits shown as *co-payments* are listed for what the *plan participant* will pay.
Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

	NETWORK	NON-NETWORK
Retail Pharmacy Option – Thirty (30) Day Supply		
Generic Drugs	$10 *co-payment*, *deductible* waived	Not Applicable
Formulary Brand Name Drugs	$30 *co-payment*, *deductible* waived	Not Applicable
Non-Formulary Brand Name Drugs	$60 *co-payment*, *deductible* waived	Not Applicable
Specialty Drugs*	70% *co-insurance*, *deductible* waived	Not Applicable
Retail Pharmacy Option – Ninety (90) Day Supply		
Generic Drugs	$25 *co-payment*, *deductible* waived	Not Applicable
Formulary Brand Name Drugs	$75 *co-payment*, *deductible* waived	Not Applicable
Non-Formulary Brand Name Drugs	$150 *co-payment*, *deductible* waived	Not Applicable
Mail Order Pharmacy Option – Ninety (90) Day Supply		
Generic Drugs	$25 *co-payment*, *deductible* waived	Not Applicable
Formulary Brand Name Drugs	$75 *co-payment*, *deductible* waived	Not Applicable
Non-Formulary Brand Name Drugs	$150 *co-payment*, *deductible* waived	Not Applicable

*If you enroll in the PrudentRx Co-Pay Program, the out-of-pocket cost for *prescriptions* covered under the PrudentRx Co-Pay Program will be $0. Otherwise, medications in the specialty tier will remain subject to 70% *co-insurance*.

Certain *preventive care prescription drugs* [including generic contraceptives (and brand contraceptives when a generic equivalent is not available)] received by a *network pharmacy* are covered at 100% and the *deductible*/*co-payment*/*co-insurance* (if applicable) is waived.

Please refer to the following websites for information on the types of payable *preventive care prescription drugs*: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**.

The *Plan* also covers certain Safe Harbor medications at the preventive rate. For a complete list of preventive and Safe Harbor medications, refer to the CVS through Meritain list at **express-scripts.com.**

Claims for reimbursement of *prescription drugs* are to be submitted to the Pharmacy Benefits Manager at the address listed in the Quick Reference Information Chart.

NOTE: For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the Drug Coverage List, which is incorporated by reference and is available from the Pharmacy Benefits Manager as listed in the Quick Reference Information Chart.

L. Schedule of Bariatric Surgery Services – Blue 002 Option

The bariatric surgery benefits are considered under the following benefit structure.

COVERED SERVICES	NETWORK BLUE DISTINCTION CENTER (BDC) or BDC+	SPECIAL COMMENTS
TRANSPLANTS		
Bariatric Surgery	80% *co-insurance* after *deductible*	All other related services will pay at the applicable benefit level. ***Pre-certification* is required.**

M. Schedule of Outpatient Dialysis Services – Blue 002 Option

The *outpatient* dialysis benefits are separate from the medical benefits and are administered by AmeriBen. Refer to the **Outpatient Dialysis Services** section of this summary plan description for additional information on *outpatient* dialysis services coverage.

COVERED SERVICES	ALL PROVIDERS	SPECIAL COMMENTS
DIALYSIS, OUTPATIENT		
Dialysis, Outpatient	80% *co-insurance* after *deductible*	The following *outpatient* dialysis services will be considered at 125% of *Medicare*, and then *Plan* benefits will apply: • facility and professional charges from *outpatient hospital*s and dialysis facilities • home dialysis charges Refer to the **Outpatient Dialysis Services** section for a further description and limitations of this benefit. ***Pre-certification* is required.**

N. Schedule of Regenexx Services – Blue 002 Option

The Regenexx stem cell treatment benefits are considered under the following benefit structure. Refer to the **REGENEXX** section of this summary plan description for additional information on transplant services coverage.

COVERED SERVICES	REGENEXX CLINCIAL PROVIDERS	SPECIAL COMMENTS
TRANSPLANTS		
Regenexx Stem Cell Treatment	80% *co-insurance* after *deductible*	Refer to the **REGENEXX** section for a further description and limitations of this benefit. All other related services will pay at the applicable benefit level. **Donor Search Limitation:** $30,000 per transplant per *plan participant*. ***Pre-certification* is required through Regenexx.**

O. Schedule of Transplant Services – Blue 002 Option

The transplant benefits are considered under the following benefit structure. Refer to the **Transplant Program** section of this summary plan description for additional information on transplant services coverage.

COVERED SERVICES	NETWORK BLUE DISTINCTION CENTER (BDC) or BDC+	SPECIAL COMMENTS
TRANSPLANTS		
Organ Transplants	80% *co-insurance* after *deductible*	Refer to the **Transplant Program** section for a further description and limitations of this benefit and any associated covered travel expenses. Cornea transplants unavailable at a *BDC* or *BDC+* will be covered at a certified network facility. All other related services will pay at the applicable benefit level. ***Pre-certification* is required.**

P. High Deductible Health Plan (HDHP)

Please refer to the *Plan's* wrap document for information on how a high deductible health plan (HDHP) works.

A qualified *high deductible health plan* (*HDHP*) with a *health savings account* (*HSA*) provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help build savings for future medical expenses. The *Plan* gives you greater control over how health care benefits are used. An *HDHP* satisfies certain statutory requirements with respect to minimum *deductibles* and *out-of-pocket limits* for both individual and family coverage. These minimum *deductibles* and maximum *out-of-pocket limits* are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

How This Plan Works

This *Plan* features higher annual *deductibles* and *out-of-pocket limits* than other traditional health plans. With the exception *of preventive care*, you must meet the annual *deductible* before the *Plan* pays benefits. It is called a *high deductible health plan* or *HDHP*.

It is paired with a *health savings account* (*HSA*). You may elect to make pre-tax contributions from your paycheck to your *HSA* each pay period. The *HDHP* provides medical and *prescription drug* coverage, and the *HSA* provides a tax-free way to help you save for health expenses in retirement. The *HDHP* gives you flexibility and discretion to determine how to use your health care benefits.

You can pay your *deductible* with funds from your *HSA*, or you can choose to pay your *deductible* out-of-pocket, allowing your *health savings account* to grow. Preventive care services are not subject to the *deductible*. These benefits are paid at 100%.

Applying Expenses to the Deductible

If you have not met your *deductible*, you will be responsible for 100% of the *allowed amount* for your health care expenses. If you use a *network* provider, the provider will submit the *claim* to the *Claims Administrator* on your behalf. If you use a *non-network* provider, your *physician* may ask you to pay for the services provided before you leave the office. In that case, you must submit your *claim* to the *Claims Administrator* to ensure your expenses are applied to the *deductible*. You will subsequently receive an *Explanation of Benefits* from the *Claims Administrator* stating how much the negotiated payment amount is and the amount for which you are responsible.

Q. Requirements for a Health Savings Account (HSA)

To be eligible for enrollment in a *health saving account*, you must:

1. be enrolled in a qualified *HDHP*
2. in general, not have any other non-*HDHP* medical coverage including coverage under a health flexible spending account or health reimbursement account

   You are allowed to have auto, dental, vision, disability, and long-term care insurance at the same time as an *HDHP*.
3. not be enrolled in a general purpose health care flexible spending account (and your spouse may not be enrolled in a general purpose flexible spending account)
4. not be enrolled in *Medicare*
5. not be claimed as a *dependent* on someone else's tax return

Qualified Medical Expenses

A partial list is provided in IRS Publication 502, available at **www.irs.gov**.

R. Schedule of Medical Benefits – Green 003 Option

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Calendar Year The *network* and *non-network deductible* amounts do not accumulate towards each other. *Co-insurance* do not apply to the *deductible*. *Prescription drug* charges apply to the *deductible*.		
Per *plan participant*	$3,400	$6,800
Per *family unit*	$6,800	$13,600
Family Unit - Embedded Deductible If you are enrolled in the family option, your *Plan* contains two (2) components: an individual *deductible* and a *family unit deductible*. Having two (2) components to the *deductible* allows for each member of your *family unit* the opportunity to have your *Plan* cover medical expenses prior to the entire dollar amount of the *family unit deductible* being met. The individual *deductible* is embedded in the family *deductible*. **For example,** if you, your spouse, and child are on a family plan with a $6,800 *family unit* embedded *deductible*, and the individual *deductible* is $3,400, and your child *incurs* $3,400 in medical bills, their *deductible* is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year*, even though the *family unit deductible* of $6,800 has not been met yet.		
Maximum Out-of-Pocket Limit, per Calendar Year The *out-of-pocket limit* includes *co-payments, co-insurance, deductibles,* and covered *prescription drug* charges. The *network* and *non-network out-of-pocket limits* do not accumulate towards each other.		
Per *plan participant*	$3,400	$9,000
Per *family unit*	$6,800	$18,000
Family Unit - Embedded Out-of-Pocket Limit If you are enrolled in the *family unit* option, your *Plan* contains two (2) components: an individual *out-of-pocket limit* and a *family unit out-of-pocket limit*. Having two (2) components to the *out-of-pocket limit* allows each member of your *family unit* the opportunity to have their *covered charges* be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the *family unit out-of-pocket limit* being met. The individual *out-of-pocket limit* is embedded in the *family unit out-of-pocket limit*.		
The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise. **NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the Plan:** 1. cost containment penalties 2. amounts over *the maximum allowable charges* 3. charges not covered under the *Plan* 4. *balance billed* charges		

Benefits shown as *co-payments* are listed for what the *plan participant* will pay.

Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply.
Acupuncture	100% *co-insurance* after *deductible*		**Calendar Year Maximum:** ten (10) visits, combined with massage therapy
Advanced Imaging	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Includes Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans, excluding services rendered in an emergency room setting. ***Pre-certification* is required.**
Allergy Services			
Allergy Testing	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Allergy Serum & Injections	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Ambulance Service	100% *co-insurance* after *deductible*		***Pre-certification* is required** for non-emergent air ambulance. Please refer to the **Medical Benefits** section, Covered Medical Charges, Ambulance, for a further description and limitations of this benefit.
Chiropractic Treatment	100% *co-insurance* after *deductible*		All services provided during the chiropractic visit will apply to the chiropractic benefit. *Spinal manipulations* apply to the chiropractic provider's benefit level. **Calendar Year Maximum:** twenty (20) visits
Dental Injury	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Diagnostic Testing	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Durable Medical Equipment (DME)	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	***Pre-certification* is required** for *DME* in excess of $3,000 purchase/rental price.
Emergency Room	100% *co-insurance* after *deductible*		The emergency room *co-payment* applies to the facility charges only. The *co-payment* applies per visit. The emergency room *co-payment* is waived if admitted.

003 Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Gender	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Treatment for gender conditions. Refer to the Travel Expenses provision in the Covered Medical Charges for applicable travel benefits.
Hearing			
Hearing Aids	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	**Benefit Maximum:** $2,500 per ear every three (3) years. Batteries do not apply to the maximum.
Hearing Exam (Diagnostic)	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Hearing Exam (Routine)	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Implantable Hearing Devices	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Home Health Care	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	**Calendar Year Maximum:** ninety (90) visits **Intermittent nurse services are limited to one (1) nurse at any one time, not to exceed four (4) hours per twenty-four (24) hour period.** ***Pre-certification* is required.**
Hospice Care	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Infertility Testing and Treatment	100% *co-insurance* after *deductible*	100% *co-insurance* after *deductible*	**Lifetime Maximum:** $20,000. Artificial insemination does not apply to this limit. *Infertility* benefit covers services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an *illness* causing an *infertility* condition when such treatment is performed in an attempt to bring about a pregnancy.
Inpatient Hospital			
Physician Visits	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Room and Board	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	**Limited to the semi-private room rate when such semi-private room rate is available.** ***Pre-certification* is required.**
Lab & X-Ray	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Lab and x-ray services billed in an outpatient hospital setting or by an independent lab.
Massage Therapy	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	**Calendar Year Maximum:** ten (10) visits, combined with acupuncture
Mastectomy Bras/Camisoles	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	**Calendar Year Maximum:** mastectomy bra and camisole purchases up to six (6) total items

003 Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Maternity			
Non-Routine Services	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Routine Services	100% *co-insurance*, *deductible* waived	50% *co-insurance* after *deductible*	
Mental Disorders & Substance Use Disorder			
Inpatient	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Includes residential treatment facility. ***Pre-certification* is required.**
Office	100% *co-insurance* after *deductible*		
Outpatient (Other)	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	Includes partial hospitalization and intensive *outpatient* program. ***Pre-certification* is required** for partial hospitalization and intensive *outpatient* program in excess of twenty-five (25) visits per *calendar year* per therapy type.
Morbid Obesity	100% *co-insurance* after *deductible*	100% *co-insurance* after *deductible*	
Nutritional Counseling/ Therapy	100% *co-insurance* after *deductible*		
Office Visit			
Primary Care Physician	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Specialist	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Prosthetics	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	***Pre-certification* is required** for prosthetics in excess of $3,000 purchase price.
Outpatient Observation Stays	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	After twenty-three (23) observation hours, a confinement will be considered at this benefit level. Prior to twenty-three (23) observation hours, benefits will pay at the applicable benefit level.
Outpatient Surgery	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	***Pre-certification* is required for certain surgical procedures.** Refer to Health Care Management Program, Pre-Certification for details.
Rehabilitation Facility	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	**Calendar Year Maximum:** ninety (90) days ***Pre-certification* is required.**
Respiratory Therapy	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Retail Clinic Visits	100% *co-insurance* after *deductible*		
Skilled Nursing Facility	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	**Calendar Year Maximum:** ninety (90) days ***Pre-certification* is required.**

003 Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Sterilization (Male)	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Telemedicine			
LiveHealth Online	100% *co-insurance*, *deductible* waived	Not Applicable	Telemedicine benefit provided through Anthem at **www.livehealthonline.com**.
All Other Vendors (Primary Care Physician)	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
All Other Vendors (Specialist)	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	
Therapy Services			
Physical Therapy Occupational Therapy Speech Therapy	100% *co-insurance* after *deductible*	50% *co-insurance* after *deductible*	***Pre-certification* is required** for physical therapy, occupational therapy, and speech therapy in excess of twenty-five (25) visits per *calendar year* per therapy type.
Travel	100% *co-insurance* after *deductible*	Not Covered	**Adoptive Cell Therapy, Gender Dysphoria, Gene Therapy, and Transplant Benefit Maximum:** $10,000 per *calendar year*, each **Bariatric Surgery and Covered Restrictive Services:** $2,000 per *calendar year*, each Refer to the **Medical Benefits** section for a further description and limitations of this benefit and any associated covered travel expenses.
Urgent Care	100% *co-insurance* after *deductible*		
Wigs	100% *co-insurance* after *deductible*		Limited to hair loss related to chemotherapy, radiation therapy, burns, alopecia, or behavioral health conditions. **Calendar Year Maximum:** $500. Includes coverage for wigs purchased over the counter.

003 Option

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), the IRS Safe Harbor preventive services list, or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network* provider at a Routine Wellness Care visit. If there are no *network* providers who perform or provide the service, then *non-network* providers will be covered at the *network* level. For more information about preventive services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations** **www.hrsa.gov** **Safe Harbor Services:** **https://www.irs.gov/pub/irs-drop/n-04-23.pdf** **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** Non-Preventive Care services which are ordered or performed at a Routine Wellness Care visit are not considered under the Preventive Care benefit. Those services will apply to their applicable benefit level or exclusion as appropriate.			
Routine Wellness Care	100% *co-insurance*, *deductible* waived	50% *co-insurance* after *deductible*	Services include routine physical exam, labs and x-rays, immunizations, gynecological exam, pap smear, PSA test, 2D and 3D mammogram, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. **Calendar Year Maximum:** One (1) visit per adult *plan participant*. This maximum does not include the well woman visit. Please refer to the **Medical Benefits** section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Breastfeeding Pump and Supplies	100% *co-insurance*, *deductible* waived		Breastfeeding support and supplies. Breast pumps purchased over the counter will be covered. ***Pre-certification* is required for breastfeeding pumps in excess of $500 purchase/rental price.**
Contraceptive Services	100% *co-insurance*, *deductible* waived	50% *co-insurance* after *deductible*	Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion. **Benefit Limitations:** Services are available to all female *plan participants*.

Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.

S. Schedule of Prescription Drug Benefits – Green 003 Option

The *prescription drug* benefits are separate from the medical benefits and are administered by CVS through Meritain. Refer to the **Prescription Drug Benefits** section of this summary plan description for additional information on *prescription drug* coverage.

Prescription drug charges do apply to the medical *deductible*.
Prescription drug charges do apply to the medical *out-of-pocket* maximum.

Benefits shown as *co-payments* are listed for what the *plan participant* will pay.
Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

	NETWORK	NON-NETWORK
Retail Pharmacy Option – Thirty (30) Day Supply		
Generic Drugs	100% *co-insurance* after *deductible*	Not Applicable
Formulary Brand Name Drugs	100% *co-insurance* after *deductible*	Not Applicable
Non-Formulary Brand Name Drugs	100% *co-insurance* after *deductible*	Not Applicable
Specialty Drugs*	100% *co-insurance* after *deductible*	Not Applicable
Retail Pharmacy Option – Ninety (90) Day Supply		
Generic Drugs	100% *co-insurance* after *deductible*	Not Applicable
Formulary Brand Name Drugs	100% *co-insurance* after *deductible*	Not Applicable
Non-Formulary Brand Name Drugs	100% *co-insurance* after *deductible*	Not Applicable
Mail Order Pharmacy Option – Ninety (90) Day Supply		
Generic Drugs	100% *co-insurance* after *deductible*	Not Applicable
Formulary Brand Name Drugs	100% *co-insurance* after *deductible*	Not Applicable
Non-Formulary Brand Name Drugs	100% *co-insurance* after *deductible*	Not Applicable

*If you enroll in the PrudentRx Co-Pay Program, the out-of-pocket cost for *prescriptions* covered under the PrudentRx Co-Pay Program will be $0. Otherwise, medications in the specialty tier will remain subject to 70% *co-insurance*.

Certain *preventive care prescription drugs* [including generic contraceptives (and brand contraceptives when a generic equivalent is not available)] received by a *network pharmacy* are covered at 100% and the *deductible*/*co-payment*/*co-insurance* (if applicable) is waived.

Please refer to the following websites for information on the types of payable *preventive care prescription drugs*:
https://www.healthcare.gov/coverage/preventive-care-benefits/ or
http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.

The *Plan* also covers certain Safe Harbor medications at the preventive rate. For a complete list of preventive and Safe Harbor medications, refer to the CVS through Meritain list at **express-scripts.com.**

Claims for reimbursement of *prescription drugs* are to be submitted to the Pharmacy Benefits Manager at the address listed in the Quick Reference Information Chart.

NOTE: For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the Drug Coverage List, which is incorporated by reference and is available from the Pharmacy Benefits Manager as listed in the Quick Reference Information Chart.

T. Schedule of Bariatric Surgery Services - Green 003 Option

The bariatric surgery benefits are considered under the following benefit structure.

COVERED SERVICES	NETWORK BLUE DISTINCTION CENTER (BDC) or BDC+	SPECIAL COMMENTS
TRANSPLANTS		
Bariatric Surgery	100% *co-insurance* after *deductible*	All other related services will pay at the applicable benefit level. ***Pre-certification* is required.**

U. Schedule of Outpatient Dialysis Services – Green 003 Option

The *outpatient* dialysis benefits are separate from the medical benefits and are administered by AmeriBen. Refer to the **Outpatient Dialysis Services** section of this summary plan description for additional information on *outpatient* dialysis services coverage.

COVERED SERVICES	ALL PROVIDERS	SPECIAL COMMENTS
DIALYSIS, OUTPATIENT		
Dialysis, Outpatient	100% *co-insurance* after *deductible*	The following *outpatient* dialysis services will be considered at 125% of *Medicare*, and then *Plan* benefits will apply: • facility and professional charges from *outpatient hospital*s and dialysis facilities • home dialysis charges Refer to the **Outpatient Dialysis Services** section for a further description and limitations of this benefit. ***Pre-certification* is required.**

V. Schedule of Regenexx Services - Green 003 Option

The Regenexx stem cell treatment benefits are considered under the following benefit structure. Refer to the **REGENEXX** section of this summary plan description for additional information on transplant services coverage.

COVERED SERVICES	REGENEXX CLINCIAL PROVIDERS	SPECIAL COMMENTS
TRANSPLANTS		
Regenexx Stem Cell Treatment	100% *co-insurance* after *deductible*	Refer to the **REGENEXX** section for a further description and limitations of this benefit. All other related services will pay at the applicable benefit level. **Donor Search Limitation:** $30,000 per transplant per *plan participant*. ***Pre-certification*** **is required through Regenexx.**

W. Schedule of Transplant Services – Green 003 Option

The transplant benefits are considered under the following benefit structure. Refer to the **Transplant Program** section of this summary plan description for additional information on transplant services coverage.

COVERED SERVICES	NETWORK BLUE DISTINCTION CENTER (BDC) or BDC+	SPECIAL COMMENTS
TRANSPLANTS		
Organ Transplants	100% *co-insurance* after *deductible*	Refer to the **Transplant Program** section for a further description and limitations of this benefit and any associated covered travel expenses. Cornea transplants unavailable at a *BDC* or *BDC+* will be covered at a certified network facility. All other related services will pay at the applicable benefit level. ***Pre-certification* is required.**

SECTION VI—MEDICAL BENEFITS

Medical benefits apply when *covered charges* are *incurred* for care of an *injury* or *illness* while a *plan participant* is covered for these benefits under the *Plan*.

A. Covered Medical Charges

Covered charges are the *maximum allowable charges* that are *incurred* for the following items of service and supply. These charges are subject to the benefit limits, exclusions, and other provisions of this *Plan*. A charge is *incurred* on the date that the service or supply is performed or furnished.

1. **Abortion.** Services, supplies, care, drugs, or treatment in connection with an elective abortion.
2. **Acupuncture.** Expenses *incurred* for acupuncture, including acupuncture administered by a *physician*, licensed for this treatment, and is also covered when provided in lieu of anesthetic. Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.
3. **Adoptive Cell Therapy.** For FDA approved adoptive cell therapy such as chimeric antigen receptor T-cell (CAR T) therapy along with associated services and supplies. ***Pre-certification* is required**. Refer to the Travel Expenses provision in the Covered Medical Charges for applicable travel benefits.
4. **Advanced Imaging.** Charges for advanced imaging, including Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans. Charges include the readings of these medical tests/scans. ***Pre-certification* is required.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
5. **Allergy Services.** Charges for allergy testing and the cost of the resultant serum preparation (antigen) and its administration, when rendered by a *physician* or in the *physician's* office. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
6. **Ambulance.** Benefits will be provided for licensed ground, air, and water ambulance services used to transport you from the place where you are *injured* or stricken by *illness* to the nearest accredited general *hospital* with adequate facilities for treatment.

   Inter-facility transport is available to a *network hospital* after you have been stabilized at a *non-network hospital* or to the nearest accredited general *network hospital* with adequate facilities for treatment as deemed *medically necessary*.

   Charges for services requested for a licensed ground, air, or water ambulance service, when the patient is not transported, will be covered by the *Plan*. Services for chartered flights will not be covered by the *Plan*. ***Pre-certification* is required for non-emergent air ambulance.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
7. **Anesthetics.** Includes anesthetic, oxygen, intravenous injections/solutions, and the administration of these items.
8. **Blood.** Non-replaced blood, blood plasma, blood derivatives, and their administration and processing.
9. **Cardiac Rehabilitation.** Cardiac rehabilitation as deemed *medically necessary*, provided services are rendered in a *medical care facility* as defined by this *Plan*.

   Coverage will be limited to phase one (1) and phase two (2).
10. **Chemotherapy/Radiation.** Radiation or chemotherapy and treatment with radioactive substances, including materials and services of technicians. ***Pre-certification* is required for certain services within these categories. Refer to Health Care Management Program for details.**
11. **Chiropractic.** Includes maintenance therapy. Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.
12. **Circumcision.** All circumcisions are covered.
13. **Clinical Trials.** This *Plan* will cover routine patient costs for a *qualified individual* participating in an *approved clinical trial* , as demonstrated via a signed consent form or proof of enrollment, that is conducted in connection with the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an *investigational* new drug application reviewed by the Food and Drug

Administration, or is exempt from *investigational* new drug application requirements. Refer to the Medical Plan Exclusions subsection for a further description and limitations of this benefit. ***Pre-certification* is required.**

14. **Contraceptives.** Injections, implants, devices, and associated *physician* charges are covered under the *Preventive Care* provision of this *Plan*. Self-administered contraceptives (not over-the-counter), are covered under the **Prescription Drug Benefits** section of this *Plan*.

15. **Dental Injuries.** *Injury* to or care of the mouth, teeth, gums, and alveolar processes will be *covered charges* under this *Plan* only if that care is initiated within twelve (12) months following the *injury* and is for the following oral *surgical procedures*:

    a. *emergency* repair due to *injury*

    b. *surgery* needed to correct *accidental injuries* to the jaws, cheeks, lips, tongue, floor, and roof of the mouth

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

    NOTE: No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease*, and preparing the mouth for fitting of or continued use of dentures.

16. **Diabetic Education.** Services and supplies used in *outpatient* diabetes self-management programs are covered under this *Plan* when they are provided by a *physician*.

17. **Diagnostic Testing.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

18. **Durable Medical Equipment (DME).** The total rental fee for *durable medical equipment* will not exceed the purchase price of the equipment. If the purchase price is not available, rental is allowed for the lifetime of the equipment. Repair, delivery, set-up, and education charges pertaining to DME are covered.

    ***Pre-certification* is required when the purchase and/or rental price is expected to exceed $3,000.**

    Replacement of purchased equipment is covered if either:

    a. the replacement is needed because of a change in your physical condition

    b. it is likely to cost less to replace the item than to repair the existing item or rent a similar item

    Maintenance and repairs needed due to misuse or abuse are not covered.

    The following items will be considered under the DME benefit:

    a. **Diabetic Equipment.** Includes insulin pumps and supplies, glucometers and supplies, and continuous glucose monitors. For additional diabetic supplies, refer to the **Prescription Drug Benefits** section of this *Plan*.

       Visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of diabetic equipment and supplies related *preventive care* benefits.

    b. **Foot Orthotics.** Custom molded foot orthotics limited to one (2) pair or two (4) units per *calendar year*.

    c. **Oxygen.** Oxygen and its administration, including oxygen concentrators. Oxygen concentrators are not subject to purchase price requirements.

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

19. **Family History.** Charges related to services provided with a diagnosis of family history, including as covered under applicable federal law.

20. **Foot Care.** Treatment for metabolic or peripheral-vascular *disease,* plantar fasciitis, neuromas, nail bed removal, or cutting/surgical procedures when *medically necessary* and not otherwise excluded. Includes prescribed diabetic shoes limited to two (2) pair or four (4) units per *calendar year*. Refer to the *DME* covered charge for custom molded foot orthotics. Non-custom molded foot orthotics are not covered.

21. **Genetic/Genomic Testing and Counseling.** Genetic and genomic testing to identify the potential for, or existence of, a medical condition and/or to examine abnormalities in groups of genes to aid in designing specific treatment options for an individual's condition as mandated by PPACA or as *medically necessary*.

    ***Pre-certification* is required.**

    Refer to the **Federal Notices** section for the statement of rights under the Genetic Information Nondiscrimination Act of 2008 (GINA).

22. **Hearing.**

    Hearing Exams. Charges for routine and diagnostic hearing exams.

    Hearing Aids. Charges for services, supplies, and hearing exams in connection with hearing aids and exams for their fitting. Batteries for related hearing devices are also covered. Over-the-counter hearing aids are not covered. Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.

    Implantable Hearing Devices. Charges for services, supplies, and hearing exams in connection with implantable hearing devices, including, but not limited to, cochlear implants and exams for their fitting. Benefits include aural therapy in connection with covered implantable hearing devices and apply to the Speech Therapy benefit level. See the Speech Therapy benefit in the applicable Schedule of Medical Benefits subsection for any applicable benefit maximum.

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

23. **Home Health Care.** Charges for *home health care services and supplies* are covered only for care and treatment of an *illness* or *injury* when *hospital* or *skilled nursing facility* confinement would otherwise be required. The diagnosis, care, and treatment must be certified by the attending *physician* and be contained in a *home health care plan*.

    a. Benefit payment for nursing, home health aide, and therapy services are subject to the home health care limit shown in the applicable Schedule of Medical Benefits.

    b. A home health care visit will be considered a periodic visit by a *physician* acting within the scope of their license and/or as defined under *home health care services*.

    ***Pre-certification* is required.** Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.

24. **Home Infusion Therapy.** Home infusion therapy does not apply to the home health care maximum.

25. **Home Visits.** When a provider visits the home for covered services, commonly known as a 'house call.' This is separate from home health care and therapy done in the home.

26. **Hospice Care.** *Hospice care services and supplies* for *plan participants* . Services must be rendered by a state-licensed *hospice care agency* and included in a written *hospice care plan* established and periodically reviewed by the attending *physician*. The *physician* must certify the *plan participant* is terminally *ill* and that *hospital* confinement would be required in the absence of the hospice care. The *hospice care plan* shall also describe the services and supplies for palliative care and treatment to be provided to the *plan participant* by the *hospice care agency*. Benefits are provided for:

    a. medical supplies

    b. visits by a *physician*

    c. bereavement counseling services for the hospice patient's immediate family (covered spouse and/or other covered *dependents*)

       Bereavement services must be furnished within six (6) months after the patient's death. A licensed pastoral counselor will be considered a covered provider for purposes of bereavement counseling, subject to all other *Plan* provisions.

       NOTE: Bereavement counseling in connection with the *Plan's hospice care services* does **not** require *pre-certification*.

    d. respite care up to eight (8) hours per week

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.

27. **Hospital Care.** The medical services and supplies furnished by a *hospital*, *ambulatory surgical facility*, or a *birthing center*. ***Pre-certification* is required for inpatient admissions.** Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.

    a. Private room charges will be paid at the semi-private room rate when such semi-private room rate is available.

    b. Charges for an *intensive care unit* stay do not apply to the semi-private room rate.

    c. Services for general anesthesia and related *hospital* or *ambulatory surgical center* services are covered for dental procedures if any of the following conditions apply:

       i. The *plan participant* is under age seven (7).

ii. The *plan participant* is disabled physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office.

iii. The *plan participant* has a medical condition besides the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment were not done in a *hospital* or *ambulatory surgical center*.

This benefit does not cover the *dentist's* services.

28. **Impotence.** Diagnostic benefits only, in connection with treatment for organic impotence. Medication is covered under the Prescription Drug Benefits.

29. **Infertility.** Services include office visits, initial *diagnostic testing*, and treatment. This does not include infertility services for *plan participants* who have undergone voluntary sterilization. Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.

30. **Laboratory Studies.** *Covered charges* for diagnostic lab testing and services.

31. **Lenses.** The initial purchase of eyeglasses, contact lenses, or intraocular lenses for the following conditions:

    a. following cataract surgery

    b. damaged lens due to eye trauma

    c. congenital cataract

    d. congenital aphakia

    e. lens subluxation/displacement

    f. anisometropia of two (2) diopters or greater, and uncorrectable vision with the use of glasses or contacts

    g. replacement of a previously implanted intraocular lens due to anatomical change, inflammatory response, or mechanical failure

32. **Mastectomy Bras and Camisoles.** Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.

33. **Maternity.** *Pregnancy* and complications of *pregnancy* shall be covered as any other *illness* for the *employee* or spouse. *Dependent* child *pregnancy* is covered. Benefits include pre-and post-natal care, obstetrical delivery, caesarean section, miscarriage, and complications resulting from the *pregnancy*. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

    NOTE: Breastfeeding maintenance, breast milk storage supplies, pump parts, and other supplies are also available as outlined in the applicable Schedule of Medical Benefits. Lactation counseling will be paid as other preventive services.

    Visit **https://www.healthcare.gov/coverage /preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations** for a current listing of required *pregnancy*-related *preventive care* benefits.

    Delivery and hospitalization stay may be subject to *pre-certification* if over the standards set forth in the Newborns' and Mothers' Health Protection Act. Refer to the **Federal Notices** section for the statement of rights under the Newborns' and Mothers' Health Protection Act for certain protections mothers and newborns have regarding *hospital* stays.

34. **Medical Foods.** Enteral (tube feedings) and parenteral (intravenous/IV) medical foods are considered a *covered charge*. Medical foods taken orally are not covered under the *Plan*, except for PKU formula.

35. **Medical Supplies.** Charges for surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations. Also included are supplies and dressings in instances such as surgical wounds, cancer, burns, diabetic ulcers, colostomy bags and catheters, ostomy supplies, and surgical and orthopedic braces, unless covered under the **Prescription Drug Benefits** section. Jobst/compression stockings are limited to two (2) pair or four (4) units per *calendar year*.

    Visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of medical supplies related *preventive care* benefits.

36. **Mental Disorders and Substance Use Disorder.** Coverage for mental health treatments are considered the same as benefits provided for other medical conditions. *Inpatient* and *outpatient* treatment for *mental*

disorders, including bereavement counseling, behavioral/learning disabilities, developmental delay, family counseling when billed with an otherwise covered diagnosis, and group counseling will be eligible when rendered by a licensed psychiatrist or licensed psychologist or when rendered by a *physician* as defined. Includes *applied behavioral analysis* (*ABA*) therapy and testing, psychiatric day treatment, residential treatment, partial hospitalization, and intensive *outpatient* programs. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

***Pre-certification* is required** for partial hospitalization and intensive *outpatient* program in excess of twenty-five (25) visits per *calendar year* per therapy type, and inpatient admissions**.**

Refer to the **Federal Notices** section for the statement of rights under the *Mental Health Parity and Addiction Equity Act of 2008.*

37. **Midwife Services.** Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of their license. This *Plan* will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries.
38. **Morbid Obesity.** Charges for the care, treatment, and counseling of *morbid obesity*. Reversals are not covered. *Covered charges* for bariatric surgery will be payable as shown in the applicable Schedule of Bariatric Surgery Services.
39. **National/Public Health Emergency.** In the event of a declared National Health Emergency (or Public Health Emergency), the *Plan* will offer coverage as mandated for the conditions as required by federal regulation. The *Plan* will also cover medications authorized for emergency use (EUA medications) by the appropriate federal agencies in the event of a public health emergency. This provision shall override any potentially conflicting, specific exclusions, defined terms, or other *Plan* provisions as necessary to provide, and limited to, any mandated services as outlined in the national and/or public health emergency, and corresponding regulation(s). Such coverage shall remain in effect until the national and/or public health emergency, as declared by the governing federal agency, has ended.
40. **Neuropsychological Testing.** Tests used to evaluate patients who have experienced a traumatic brain injury, brain damage, or organic neurological problems (e.g., dementia). May also be used to evaluate the progress of a patient who has undergone treatment or rehabilitation for a neurological *injury* or *illness*.
41. **Nutritional Counseling/Therapy.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
42. **Oral Surgery.** Care of the mouth, teeth, gums, and alveolar processes will be a *covered charge* under this *Plan* only if that care is for the following oral *surgical procedures*:
    a. excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth
    b. excision of benign bony growths of the jaw and hard palate
    c. external incision and drainage of cellulitis
    d. incision of sensory sinuses, salivary glands, or ducts
    e. removal of all teeth at an *inpatient* or *outpatient hospital* or *dentist*'s office if removal of the teeth is part of standard medical treatment that is required before the *plan participant* can undergo radiation therapy for a covered medical condition
    f. organ transplant preparation
    g. orthognathic surgery/LeFort procedures to correct malposition in the bones of the jaw
    h. removal of bony impacted teeth
    i. reduction of dislocations and excision of *temporomandibular joints (TMJ)*

    NOTE: No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease,* and preparing the mouth for fitting of or continued use of dentures.
43. **Orthotic Appliances.** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints, cranial helmets, or other appliances which are required for support for an *injured* or deformed part of the body as a result of a disabling congenital condition or an *injury* or *illness*.

    Replacement of purchased equipment is covered if either:
    a. the replacement is needed because of a change in your physical condition
    b. it is likely to cost less to replace the item than to repair the existing item or rent a similar item

***Pre-certification* is required when the purchase price is expected to exceed $3,000.**

44. **Outpatient Observation Stays.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

45. **Physician Care.** The professional services of a *physician* for medical services. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed the surgeon's *maximum allowable charge*.

    Charges for **multiple *surgical procedures*** will be a *covered charge* subject to the following provisions:

    a. If bilateral or multiple *surgical procedures* are performed by one (1) surgeon, benefits will be determined based on the *maximum allowable charge* that is allowed for the primary procedures; the *maximum allowable charge* will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental, and no benefits will be provided for such procedures.

    b. If multiple unrelated *surgical procedures* are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the *maximum allowable charge* for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the *maximum allowable charge* allowed for that procedure.

    c. If a co-surgeon is required, meaning skills of both surgeons are necessary to perform distinct parts of a specific operative procedure, payment is based for each physician on the *maximum allowable charge*, dividing the payment equally between the two (2) surgeons. *Surgeries* performed by co-surgeons that have the same specialty will not exceed the *maximum allowable charge* allowed for that procedure.

46. **Pre-Admission Testing.** Includes diagnostic labs, x-rays, and EKGs that you obtain on an *outpatient* basis prior to your scheduled admission to the *hospital*. You should make sure your *hospital* will accept the results of these tests.

47. **Preventive Care.** Benefits will be provided for *preventive care,* including, but not limited to:

    a. **Adult Physical Examination, Well-Baby, and Well-Child Examinations.**

    b. **Colorectal Cancer Screening.**

    c. **Contraceptives.** Injections, implants, devices, and associated *physician* charges are covered under the medical benefits of this *Plan*. Self-administered contraceptives are covered under the Prescription Drug Benefits.

    d. **Gynecological Exam.**

    e. **Mammogram.**

    f. **Lactation Counseling.**

    g. **Pap Smear.**

    h. **Prostate Specific Antigen (PSA) Test.**

    i. **Immunizations.** Pediatric and adult preventive vaccinations, inoculations, and immunizations, as recommended by the Centers for Disease Control and Prevention (CDC)

       The *Plan* contributes to at least one (1) state-funded vaccination program, which covers the provider's costs associated with immunization serum for eligible, minor children up to the age of nineteen (19). Should a provider bill a vaccine charge for a child who is covered by that state's immunization program, regardless of their eligibility under the *Plan*, the *Plan* will consider its financial obligation of that *claim* satisfied through its contribution to the state funded immunization program and will not remit payment for that *claim*, except as may be required by applicable federal law. The administration of immunizations is covered.

       Immunizations received at a *non-network pharmacy* will be paid as *in-network* under the medical plan.

    j. **Preventive Lab and X-Ray.** Laboratory and x-ray services related to routine examinations.

    k. **Sterilization.** Services for tubal ligation or other voluntary sterilization procedures for female *plan participants*.

    l. **Tobacco Cessation.** Education, counseling, and behavioral intervention services provided by a *physician* for smoking/vaping cessation up to two (2) attempts per *calendar year*, consisting of four (4) visits lasting ten (10) minutes each.

NOTE: Additional *preventive care* shall be covered as required by applicable law if provided by a *network* provider. A current listing of required *preventive care* can be accessed at the following websites:

a. **https://www.healthcare.gov/coverage/preventive-care-benefits/**

b. **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**

c. **https://www.irs.gov/pub/irs-drop/n-04-23.pdf**

d. **https://www.irs.gov/pub/irs-drop/n-19-45.pdf**

48. **Prosthetic Devices.** The initial purchase of artificial limbs, eyes, and breast prostheses, including service and repair of an artificial limb, eye, or breast prosthesis.

Replacement of purchased equipment is covered if either:

a. the replacement is needed because of a change in your physical condition

b. it is likely to cost less to replace the item than to repair the existing item or rent a similar item

***Pre-certification* is required when the purchase price is expected to exceed $3,000.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

The following devices will be considered under the prosthetic benefit:

a. **Sleep Apnea Oral Devices.**

b. **TMJ Oral Devices.**

49. **Reconstructive Surgery.** *Reconstructive surgery* expenses are covered in the following circumstances:

a. when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part

b. to correct damage caused by an *accidental injury*

c. for breast *reconstruction* following a total or partial *mastectomy*, as follows:

i. *reconstruction* of the breast on which the *mastectomy* has been performed

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

iii. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

All other *reconstructive surgeries* will be covered under the *Plan* when *medically necessary*, except as otherwise excluded herein.

Refer to the **Federal Notices** section for the statement of rights to *surgery* and prostheses following a covered *mastectomy* under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

50. **Routine Newborn Care.** Routine well-baby care is care while the newborn is *hospital*-confined after birth and includes *room and board* and other normal care for which a *hospital* makes a charge.

This coverage is only provided if the newborn child is an eligible *dependent* and a parent either:

i. is a *plan participant* who was covered under the *Plan* at the time of the birth

ii. enrolls (as well as the newborn child if required) in accordance with the Special Enrollment Periods provisions with coverage effective as of the date of birth

The benefit is limited to *allowable charges* for well-baby care after birth while the newborn child is *hospital* confined as a result of the child's birth. Routine newborn care is subject to the mother's *deductible* and *out-of-pocket limit*. If the mother is not covered under the *Plan*, then these expenses apply to the newborn's *deductible* and *out-of-pocket limit*.

51. **Screening Services.**

52. **Second Surgical Opinion.** If your doctor recommends *surgery* or other medical treatment, it is often in your best interest to obtain a second opinion with a specialist regarding the necessity of the procedure. In many cases an alternative method of treatment is available that would save yourself the discomfort of *surgery* or other medical treatment as well as the time and extra expenses.

53. **Skilled Nursing Facility.** The *room and board* and nursing care furnished by a *skilled nursing facility* will be payable if and when:

    a. The patient is confined as a bed patient in the facility.

    b. The attending *physician* certifies that the confinement is needed for further care of the condition that caused the *hospital* confinement.

    c. The attending *physician* completes a treatment plan which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the *skilled nursing facility*.

    ***Pre-certification* is required for inpatient admissions.** Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.

54. **Sleep Disorders/Sleep Studies.** Care and treatment for sleep disorders, including sleep studies performed in the home.

55. **Sterilization.** Services for vasectomy or other voluntary sterilization procedures for male *plan participants*. Female sterilization and family planning counseling is covered under the Preventive Care provision of this *Plan*. The *Plan* does not cover the reversal of voluntary sterilization procedures, including related follow-up care. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

56. **Surgery.** Benefits for the treatment of *illnesses* and *injuries,* including fractures and dislocations, are covered for the surgeon, assistant surgeon, anesthesiologist, and surgical supplies. ***Pre-certification* is required for certain surgical procedures.** Refer to **Health Care Management Program**, Pre-Certification for details.

57. **Temporomandibular Joint Syndrome (TMJ).** Benefits for medical or dental services for treatment of *temporomandibular joint* disorders.

58. **Therapy Services.** Services include the following therapy types rendered on an *inpatient* or *outpatient* basis:

    a. **Physical Therapy.** Benefits include aquatic therapy.

    b. **Occupational Therapy.**

    c. **Speech Therapy.** Benefits include aural therapy following a covered implantable hearing device.

    Therapy in the home does not apply to the Home Health Care benefit maximum unless rendered as part of a *home health care plan*.

    Rehabilitation Services. The *Plan* covers *rehabilitation se*rvices to help a *plan participant* achieve a previous level of function, independence, and quality of life.

    Habilitation Services. The *Plan* covers *habilitation services* that help a *plan participant* keep, learn, or improve skills and functions for daily living that they may not be developing as expected for their age range.

    ***Pre-certification* is required for outpatient physical therapy, occupational therapy, and speech therapy in excess of twenty-five (25) visits per calendar year per therapy type.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

59. **Travel Expenses.** Covered travel and lodging expenses are only covered for services related to transplants, *adoptive cell therapy*, gender dysphoria, gene therapy, bariatric surgery, and covered restrictive services. The *plan participant* must be receiving services at a designated *network* facility.

    Eligible expenses for travel, lodging, and meals combined up to a maximum of $10,000 each for adoptive cell therapy, gene therapy, gender dysphoria, and transplants per *calendar year*, and, $2,000 each for covered restrictive services and bariatric surgery per *calendar year* for the *plan participant* (while not a *hospital inpatient*) and companion(s) who are traveling on the same day(s) to and/or from the site of treatment for the purposes of an evaluation, the procedure, and/or necessary post-discharge follow-up . Benefits are paid at a per diem (per day) rate of up to $50 per day for the *plan participant* or up to $100 per day for the *plan participant* plus one (1) companion. If the *plan participant* is an enrolled *dependent* and minor child, the transportation expenses of two (2) companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

    Travel and lodging expenses are only available if the *plan participant* and/or the donor (when the donor's expenses are not covered under the donor's plan) lives more than fifty (50) miles from the designated *network* facility. These benefits will be reimbursed upon the submission to the *Plan* of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service provider. Refer to the **Claims and Appeals** section for instructions on how to submit a *claim* for reimbursement. The listed expenses must be *incurred* within five (5) days prior to the procedure and one hundred twenty (120) days after the procedure. Applicable travel expenses will also be covered during the transplant evaluation period.

The *Plan Administrator* reserves the right not to reimburse any such expenses that it, in its sole discretion, deems inappropriate, excessive, or not in keeping with the intent of this provision. Examples of eligible travel expenses may include airfare (at coach rate), taxi or ground transportation, or mileage reimbursement at the IRS rate for the most direct route between the *plan participant's* home and the designated *network* facility. Refer to the Medical Plan Exclusions subsection for a further description and limitations of eligible travel expenses for reimbursement. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

60. **Virtual Visits.** Services rendered telephonically or electronically, performed by providers other than the *Plan's* telemedicine vendor, when performed for otherwise covered services. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
61. **Vision Services.** Benefits are available for vision examinations when performed in conjunction with a medical diagnosis, including refraction. Does not include contact lens fitting. Refer to the Medical Plan Exclusions subsection for limitations.
62. **Wigs**. Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.
63. **X-Rays.** Diagnostic x-rays.

B. Medical Plan Exclusions

The following list is intended to give you a general description of expenses for services and supplies that are not covered by the *Plan*. Items that are not listed as excluded may be considered based on *medical necessity*, standard of care, and medical appropriateness. This list is not exhaustive.

NOTE: All exclusions related to prescription drugs are shown in the Prescription Drug Benefits section.

1. **Alternative Medicine.** Charges for the following, including related drugs, are excluded under this *Plan*: holistic or homeopathic treatment, naturopathic services, thermography, acupressure, aromatherapy, hypnotism, rolfing (holistic tissue massage), art therapy, music therapy, dance therapy, horseback therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.
2. **Armed Forces.** Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any *plan participant* in the armed forces of a government.
3. **Athletic Training.**
4. **Biofeedback.**
5. **Cardiac Rehabilitation.** Cardiac rehabilitation phase three (3) and phase four (4).
6. **Chelation Therapy.** Except for lead poisoning.
7. **Clinical Trials.** The following items are not routine patient costs and are excluded from *approved clinical trial* coverage under this *Plan*:
    a. the *investigational* item, device, or service, itself
    b. items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the patient
    c. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

    If one (1) or more *participating providers* do participate in the *approved clinical trial*, the qualified *plan participant* must participate in the *approved clinical trial* through a *participating network* provider, if the provider will accept the *plan participant* into the trial.

    The *Plan* does not cover routine patient care services that are provided outside of this *Plan's* health care provider *network* unless *non-network* benefits are otherwise provided under this *Plan*.
8. **Complications from a Non-Covered Service.** Care, services, or treatment required as a result of complications from a treatment not covered under the *Plan*.
9. **Cord Blood.** Harvesting and storage of umbilical cord blood.
10. **Cosmetic.** *Cosmetic* procedures and attendant hospitalization, except for newborn children or due to trauma or *disease*, done for aesthetic purposes and not to restore an impaired function of the body. Complications or subsequent *surgery* related in any way to any previous *cosmetic* procedure shall not be covered, regardless of *medical necessity*.
11. **Counseling.** Benefits for counseling in the absence of *illness* or *injury*, including, but not limited to, premarital or marital counseling; education, social, or recreational therapy; sex or interpersonal relationship counseling; or counseling provided by *plan participant's* friends, *employer*, school counselor, or schoolteacher. Counseling for the purpose of family problems is excluded regardless of diagnosis.
12. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, or *custodial care*.
13. **Dental Care.** Normal dental care benefits, including any dental, gum treatments, or oral *surgery* except as otherwise specifically provided herein.
14. **Dialysis, Outpatient.** Refer to **Outpatient Dialysis Services** section for coverage.
15. **Educational or Vocational Testing.** Services for educational or vocational testing or training. Educational services such as asthma self-management education, and Lamaze, except as listed herein.
16. **Error.** Any charge for care, supplies, treatment, and/or services that are required to treat *injuries* that are sustained, or an *illness* that is contracted, including infections and complications, while the *plan participant* was under, and due to, the care of a provider wherein such *illness*, *injury*, infection, or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the

circumstances of the course of treatment that, in the opinion of the *Plan Administrator*, in its sole discretion, unreasonably gave rise to the expense.

17. **Examinations.** Any health examination required by any law of a government to secure insurance or school admissions (except school and sports physicals) or professional or other licenses, except as required under applicable federal law. Administrative/return-to-work testing related to COVID-19, except as required under applicable federal law.
18. **Excess Charges.** Any charge for care, supplies, treatment, and/or services that are not payable under the *Plan* due to application of any *Plan* maximum or limit, charges which are in excess of the *maximum allowable charge*, or services not deemed to be *reasonable* or *medically necessary*, based upon the *Plan Administrator's* determination as set forth by and within the terms of this document.
19. **Exercise Programs.** Exercise programs for treatment of any condition, except for *physician* supervised cardiac rehabilitation, occupational, or physical therapy, if covered by this *Plan*.
20. **Experimental/Investigational.** Care and treatment that is *experimental/investigational*. This exclusion shall not apply if the charge is for routine patient care for costs *incurred* by a *qualified individual* who is a *participant* in an *approved clinical trial*. Charges will be covered only to the extent specifically set forth in this summary plan description.
21. **Foot Care.** Services for routine, palliative, or *cosmetic* foot care. Examples include flat foot conditions, supportive devices for the foot (orthotics), treatment of subluxation of the foot, care of corns, bunions (except capsular or bone *surgery*), callouses, toe nails, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet. This exclusion does not apply to *medically necessary* foot care services.
22. **Foreign Travel.** Expenses for planned and/or routine services received or supplies purchased outside the United States, including those rendered on a cruise ship, are excluded under this *Plan*. Services in the case of a *medical emergency* or provided through the Global Core Program are a *covered charge*.
23. **Government Coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid, a Veteran's Administration facility, or when otherwise prohibited by applicable law. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military service-related *illness* or *injury*, benefits are not covered by this *Plan*. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military service-related *illness* or *injury*, benefits are covered by the *Plan* subject to all other applicable *Plan* provisions and as long as the charges are within this *Plan's maximum allowable charge*.
24. **Growth Hormones.** Growth hormones are covered through the Prescription Drug Benefits program. Please refer to the section entitled **Prescription Drug Benefits**.
25. **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a *physician*, except for wigs as shown in the applicable Schedule of Medical Benefits. This exclusion does not apply to hair loss services attributed to a covered medical condition.
26. **Hospice Care.** Services for spiritual counseling; services performed by a family member or volunteer workers, homemaker, or housekeeping services; food services (such as Meals on Wheels); legal and financial counseling services; and services or supplies not included in the *hospice care plan* or not specifically set forth as a hospice benefit.
27. **Hospital Employees.** Professional services billed by a *physician* or nurse who is an *employee* of a *hospital* or *skilled nursing facility* and paid by the *hospital* or facility for the service.
28. **Hospital Services.** *Hospital* services when hospitalization is primarily for *diagnostic testing*/studies or physical therapy when such procedures could have been done adequately and safely on an *outpatient* basis.
29. **Illegal Acts.** Any charge for care, supplies, treatment, and/or services for any *injury* or *illness* which is *incurred* while taking part, or attempting to take part in, an illegal activity (felonies only). It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act.
30. **Immediate Family Member.** Any charge for care, supplies, treatment, and/or services that are rendered by a provider who is related to the *plan participant* by blood or marriage or who ordinarily dwells in the *plan participant's* household.
31. **Immunizations.** Immunizations and vaccinations for the purpose of travel outside of the United States.
32. **Long Term Care.**

33. **Maternity.** Charges for services related to a scheduled home birth. Charges for services related to surrogate *pregnancy* if the surrogate is not a *plan participant*.
34. **Medicare.** Any charge for benefits that are provided, or which would have been provided had the *plan participant* enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (*Medicare*), including any amendments thereto, or under any federal law or regulation, except as provided in the sections entitled **Coordination of Benefits** and **Medicare**.
35. **Milieu Therapy.** A treatment program based on manipulation of the *plan participant's* environment for their benefit.
36. **Negligence.** Care and treatment of an *injury* or *illness* that results from activity where the *plan participant* is found by a court of competent jurisdiction and/or a jury of their peers to have been negligent in their actions, as negligence is defined by the jurisdiction where the activity occurred.
37. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
38. **No Legal Obligation.** Any charge for care, supplies, treatment, and/or services that are provided to a *plan participant* for which the provider of a service customarily makes no direct charge, for which the *plan participant* is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including, but not limited to, fees, care, supplies, or services for which a person, company, or any other entity except the *plan participant* or this benefit *Plan*, may be liable for necessitating the fees, care, supplies, or services.
39. **No Physician Recommendation.** Care, treatment, services, or supplies not recommended and approved by a *physician*. Treatment, services, or supplies when the *plan participant* is not under the regular care of a *physician*. Regular care means ongoing medical supervision or treatment which is appropriate care for the *injury* or *illness*.
40. **No Signs or Symptoms.** Charges for treatment, or services in the absence of signs or symptoms of a specific *injury*, *illness*, or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered herein or required by applicable federal law.
41. **Non-Compliance.** Any additional *inpatient* charges in connection with treatments or medications which were directly caused by, and attributed to, the patient's non-compliance with or discharge from an *inpatient hospital* or *skilled nursing facility* against medical advice. This exclusion does not apply to any subsequent emergency room visits or *outpatient* services.
42. **Non-Emergency Hospital Admissions.** Care and treatment billed by a *hospital* for *medical non-emergency care* admissions on a Friday or a Saturday. This does not apply if *surgery* is performed within twenty-four (24) hours of admission.
43. **Non-Medical Expenses.** Expenses including, but not limited to, those for preparing medical reports or itemized bills, completion of claim forms or medical records unless otherwise required by law, calling a patient to provide their test results, sales tax, shipping and handling, expenses for failure to keep a scheduled visit or appointment, *physician* or *hospital* stand-by services, holiday or overtime rates, membership or access fees, educational brochures, or reports prepared in connection with litigation.
44. **Non-Prescription Medication.** Drugs and supplies not requiring a prescription order (unless required under applicable federal law), including, but not limited to, aspirin, antacid, benzyl peroxide preparations, cosmetics, medicated soaps, food supplements, syringes, bandages, or Rogaine hair preparations, special foods or diets, vitamins, minerals, dietary and nutritional supplements, *experimental* drugs, including those labeled "Caution: Federal law prohibits dispensing without prescription," and prescription medications related to health care services which are not covered under this *Plan*.
45. **Not Actually Rendered.** Any charge for care, supplies, treatment, and/or services that are not actually rendered.
46. **Not Medically Necessary.** Any charge for care, supplies, treatment, and/or services that are not *medically necessary*, unless specifically stated as covered herein.
47. **Obesity.** Screening and counseling for obesity will be covered to the extent required under applicable federal law. Other care or treatment of obesity, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another *illness*, is not covered under the *Plan*. Specifically excluded are charges for bariatric *surgery*, including, but not limited to, gastric bypass, stapling and intestinal bypass, and lap band *surgery*, including reversals.

48. **Occupational or Workers' Compensation.** Charges for care, supplies, treatment, and/or services for any condition, *illness*, *injury*, or complication thereof arising out of or in the course of employment (including self-employment), or an activity for wage or profit. If you are covered as a *dependent* under this *Plan* and you are self-employed or employed by an *employer* that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers' compensation insurance will cover your costs, but if you do not have such coverage, fail to file, or receive a denial for failure to file timely, you may end up with no coverage at all.
49. **Orthotics.** Charges in connection with non-custom molded foot orthotics.
50. **Other than Attending Physician.** Any charge for care, supplies, treatment, and/or services by a *provider* who did not render an actual service to the *participant*. *Covered charges* are limited to those certified by a *physician* who is attending the *plan participant* as required for the treatment of *injury* or *disease* and performed by an appropriate provider. This exclusion does not apply to interdisciplinary team conferences to coordinate patient care.
51. **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-medical grade stockings/items (except as specified herein), non-*prescription drugs* and medicines, first-aid supplies, seat risers, wheelchair lifts, and non-hospital adjustable beds.
52. **Personal Injury Insurance.** Expenses in connection with an automobile *accident* for which benefits payable hereunder are, or would be otherwise covered by, mandatory *no-fault automobile insurance* or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the *plan participant* actually had such mandatory coverage. This exclusion does not apply if the *injured* person is a passenger in a non-family-owned vehicle or a pedestrian.
53. **Prescription Drugs.** Prescription drugs charges covered under the Prescription Drug Benefits, other than those covered in a *physician's* office or *inpatient* admission.
54. **Prior to Effective Date or After Termination Date.** Services, supplies, or accommodations provided prior to the *plan participant's* effective date or after the termination of coverage. In the event coverage is terminated during a *hospital* admission, the *Plan* will only consider *covered charges* as those *incurred* before coverage was terminated, unless extension of benefits applies.
55. **Private Duty Nursing.** Charges in connection with care, treatment, or services of a private duty nurse, except as included as a part of another covered service(s), as stated herein.
56. **Prohibited by Law.** Any charge for care, supplies, treatment, and/or services to the extent that payment under this *Plan* is prohibited by law.
57. **Repair of Purchased Equipment.** Maintenance and repairs needed due to misuse or abuse are not covered.
58. **Residential Accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a *hospital*, *hospice unit*, *skilled nursing facility*, *inpatient rehabilitation hospital*, or *residential treatment facility* licensed and regulated by a state or federal agency and is acting within the scope of their license.
59. **School**. Services performed in a school setting. This exclusion also applies to services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school.
60. **Self-Inflicted.** Any loss due to an intentionally self-inflicted *injury*. This exclusion does not apply in either of the following circumstances:
    a. to an *injury* resulting from being the victim of an act of domestic violence
    b. to an *injury* resulting from a medical (including both physical and *mental health*) condition
61. **Smoking/Vaping Cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under applicable federal law. Thereafter, the *Plan* will cover cessation services based on applicable benefit level. Refer to the **Prescription Drug Benefits** section for details on coverage of certain tobacco cessation medications.
62. **Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.
63. **Subrogation, Reimbursement, and/or Third-Party Responsibility.** Any charges for care, supplies, treatment, and/or services of an *injury* or *illness* not payable by virtue of the *Plan's* subrogation, reimbursement, and/or

third-party responsibility provisions. Refer to the **Reimbursement, Subrogation, and Recovery Provisions** section.

64. **Transplants.** Services and supplies that are *incurred* for care and treatment due to a bone marrow, organ, or tissue transplant are subject to the exclusions stated in the **Transplant Program** section.

65. **Travel or Accommodations.** Charges for travel accommodations, whether or not recommended by a *physician*, except for ambulance charges and other travel defined as a *covered charge* or travel required for an approved organ or tissue transplant. Refer to the **Transplant Program** section for details.

    Any of the following or similar items associated with travel:

    a. entertainment items such as alcohol, cigarettes, toys, books, movies, theater tickets, theme park tickets, flowers, greeting cards, stationary, stamps, postage, gifts, internet service, tips, coupons, vouchers, or travel tickets, frequent flyer miles

    b. convenience items such as toiletries, paper products, maid service, laundry/dry cleaning, kennel fees, babysitter/childcare, valet parking, faxing, cell phones, phone calls, newspapers

    c. mortgage, rent, security deposit, furniture, utility bills, appliances, utensils

    d. vehicle maintenance, taxi fares, parking, moving trucks/vehicles, mileage within the medical transplant facility city

    e. cash advances/lost wages

    f. rental cars, buses, taxis, or shuttle service, except as specifically approved by the *Claims Administrator*

    g. prepayments or deposits

    h. taxes

    i. travel costs for donor companion/caregiver when covered by the donor's *Plan*

    j. return visits for a transplant donor for a treatment of an *illness* found during the evaluation when covered by the donor's *Plan*

66. **Vision Care Exclusions.** Expenses for the following:

    a. routine vision examinations

    b. surgical correction of refractive errors and refractive keratoplasty procedures, including, but not limited to, Radial Keratotomy (RK), Automated Lamellar Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK)

    c. purchase, fitting, and repair of eyeglasses or lenses and associated supplies (except as specified herein)

    d. orthoptics (eye muscle exercises), orthoptic therapy, vision training, or subnormal vision aids

    e. orthokeratology lenses for reshaping the cornea of the eye to improve vision

    f. specialty lenses such as polarized lenses, transition lenses, coatings, tints, or add-ons

    g. clear lens extraction intraocular lens implant for the correction of refractive error

    h. intraocular lenses used to correct presbyopia and astigmatism

67. **War.** Any loss that is due to a declared or undeclared act of war.

68. **Weight Loss.** Weight loss or dietary control programs.

SECTION VII—OUTPATIENT DIALYSIS SERVICES

The following *outpatient* dialysis services are not included under the *network* arrangement of this *Plan:*

1. facility and professional charges from:
    a. *outpatient hospitals*
    b. dialysis facilities
2. home dialysis charges

A. Coordination with Medicare

If you are diagnosed with a condition requiring dialysis, you may be able to enroll in *Medicare*. Your *claims* will be reduced as secondary under this *Plan* regardless of enrollment status under *Medicare* for any period during which coverage under *Medicare* is (or would have been, if you had enrolled) primary to this *Plan*. Upon beginning dialysis treatments, *Medicare*, if applicable, will coordinate benefits with the *Plan* as the secondary payer for months four (4) through thirty-three (33) of the coordination period while you are receiving dialysis treatments. Your *outpatient* dialysis medical *claims* as described in this section will be considered at 125% of *Medicare's* reimbursement level.

The *Plan* will not enroll you in *Medicare*; it is your decision and your responsibility to enroll in *Medicare*, if applicable.

If you are eligible but do not enroll for both Part A and Part B of *Medicare*, the *Plan* will pay benefits as if you have enrolled. Your *claims* will be reduced as secondary under this *Plan* regardless of enrollment status under *Medicare*.

Refer to the **Coordination of Benefits** and **Medicare** sections of this document for more information.

B. Medical Management

All dialysis services require *pre-certification*. To begin the *pre-certification* process, call AmeriBen at 1-866-215-0975.

C. ID Cards

Plan participants requiring dialysis services will be issued a separate Dialysis Identification Card. This card will be sent to you by AmeriBen upon your initial *pre-certification* call.

D. Submitting Outpatient Dialysis Claims

All *outpatient* dialysis medical *claims* will be submitted to:

AmeriBen
P.O. Box 7186
Boise, ID 83707

Please refer to the **Claims and Appeals** section for information regarding filing *claims*.

SECTION VIII—TRANSPLANT PROGRAM

A. Transplant Program

The Transplant Program provides access to a *network* of transplant centers that perform many transplants each year and have historically high success rates. They are often affiliated with renowned teaching and research facilities with access to experienced surgeons and advanced medical techniques. Using a *hospital* with transplant experience can result in shorter *hospital* stays, fewer complications, and fewer repeat transplants.

Under the Transplant Program, the *Plan* reimburses you for covered services and supplies arising out of *medically necessary* organ and tissue transplants.

When the donor of an organ or tissue is not a *plan participant*, the donor's *hospital*, surgical, and medical expenses will be eligible on the basis of a *claim* made by the *plan participant* only to the extent of what is not covered by the donor's Plan. Donors are allowed the same benefits as the *plan participant*, to the extent of what is not covered by the donor's *Plan*.

Medical and surgical treatment or devices related to transplantation that are *experimental*, *investigational*, or unproven are those not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, subject to review and approval by any Institutional Review Board for the proposed use; or non-demonstrative through prevailing peer-reviewed medical literature to be efficacious for the treatment of the *disease* state at the time of the request. The *Plan* reserves the right to make final judgment regarding coverage of *experimental*, *investigational*, and unproven procedures and treatments. *Medically necessary* means those transplant-related services which are determined by the *Plan* to be medically appropriate for the diagnosis and clinical status of the *plan participants* and their *dependents*, rendered in an appropriate setting, and of demonstrated medical value. The fact that a *physician* has performed or prescribed a transplant-related service, or the fact that it may be the only treatment for a *disease,* does not mean that is *medically necessary*.

Transplant-related services are services and supplies up to one (1) year following the transplant, which are related to transplantation when recommended by a *physician*, provided at or arranged by a transplant *hospital*, and determined to be *medically necessary*. Such services and supplies include, but are not limited to, *hospital* charges, *physician* charges, organ acquisition charges, tissue typing donor search charges, and ancillary services.

B. Program Benefits

1. access to a *network*
2. services of a transplant case manager, who will coordinate services and savings

Refer to the travel provisions in the **Medical Benefits** section.

C. Requirements

Transplant benefits under the *Plan* are only available when a *plan participant* fully utilizes a transplant network, *network Blue Distinction Center* (*BDC*) or *BDC*+ and meets all of the following requirements:

1. *Pre-certification* **must** be obtained as outlined in the **Health Care Management Program** section.
2. All transplant services must be rendered at a *Blue Distinction Center* (*BDC*) or *BDC*+.

   Certain transplant procedures are not available at a *Blue Distinction Center* (*BDC*) or *BDC*+. In these instances, the *Plan* provides coverage for the procedure and reimbursement of travel expenses to the closest available *network* location that performs the procedure. Cornea transplants are not required to be performed in a *Blue Distinction Center* (*BDC*) or *BDC*+.

If these requirements are not met, transplant benefits are not available under the Plan.

D. Transplant Exclusions

The following transplant-related expenses are not covered by the *Plan*:

1. when the recipient is not an eligible *plan participant*
2. when the organ or tissue is sold rather than donated to the recipient

3. charges related to transportation costs, including without limitation ambulance or air services for the donor or to move a donated organ or tissue
4. charges that are covered or funded by governmental, foundation, or charitable grants or programs
5. services for a condition that is not directly related, or a direct result, of the transplant

   All other covered services will fall to the applicable benefit as billed and will be subject to all other *Plan* provisions.
6. expenses for organ and tissue acquisition/procurement and storage of cord blood, stem cells, or bone marrow, unless the *plan participant* has been diagnosed with a condition for which there would be approved transplant services
7. expenses for any post-transplant complications of the donor, if the donor is not a *plan participant* under this *Plan*
8. transplants considered *experimental*, *investigational*, or unproven unless covered under a qualifying clinical trial

SECTION IX—REGENEXX

A. Coverage Enhancement

IMA Financial Group, Inc. members may pursue Regenexx stem cell treatment at Regenexx Clinical Providers through their Regenexx corporate provider *network* as an alternative to other surgical procedures. The Regenexx procedures are not considered investigational within this *summary plan description*.

B. Utilization Review

Regenexx conducts an internal utilization review. Procedures will only be approved when a patient is a clear surgical candidate and the intended Regenexx procedure has a high probability of providing cost-savings to the plan. Regenexx services are not subject to external utilization review.

C. Coverage of Regenexx Services

Preferred Provider Organization

All services billed by a Regenexx provider under the Regenexx contract with IMA Financial Group, Inc. will be covered at 80% by the plan after plan members have met the deductible.

High-Deductible Plan

For participants on a high-deductible health plan, Regenexx services will be covered at 100% after plan members have met the deductible.

D. Relationship with Provider

The relationships between IMA Financial Group, Inc., AmeriBen, and all providers are solely contractual relationships between independent contractors. No provider participating in the Plan is an employee or agent of the Plan or IMA Financial Group, Inc., or an agent or employee of AmeriBen. No IMA Financial Group, Inc. or AmeriBen employee is an agent or employee of any provider participating in the Plan.

IMA Financial Group, Inc. and AmeriBen do not provide health care services or supplies, nor do they practice medicine. Instead, IMA Financial Group, Inc. and AmeriBen arrange for health care providers to participate in the Plan. Providers participating in the Plan are independent practitioners who run their own offices and facilities. Neither IMA Financial Group, Inc. nor AmeriBen assure the quality of the services provided. IMA Financial Group, Inc. and AmeriBen are not liable for any act of omission of any provider.

E. Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. IMA Financial Group, Inc. and AmeriBen do not decide what care you need or will receive. You are responsible for choosing your own provider and must decide with your provider what care you should receive. Your provider is solely responsible for the quality of services provided to you.

F. Billing

Regenexx Corporate Billing Services located at PO Box 209414, Dallas, TX 75320-9414 will be the billing entity for these medical services. Claims will be processed according to the agreed upon fee schedule with Regenexx. Any payment made to the patient with regard to the Regenexx fee schedule must be forwarded by the patient to Regenexx.

SECTION X—HEALTH CARE MANAGEMENT PROGRAM

A. Introduction

The health care management program consists of several components to assist *plan participants* in staying well: providing optimal management of chronic conditions, provisions of support, and service coordination during times of acute or new onset of a medical condition.

The scope of the health care management program consists of the following components (each of which will be further discussed in this section):

1. utilization review
2. concurrent review and discharge planning
3. case management
4. health management
5. maternal health program

B. Utilization Review

The utilization review program is designed to help ensure all *plan participants* receive *medically necessary* and appropriate health care while avoiding unnecessary expenses.

The purpose of the program is to determine what services are *medically necessary* and eligible for payment by the *Plan*. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending *physician* or other health care provider.

If a particular course of treatment or medical service is not *pre-certified*, it means that either the *Plan* will not pay for the charges, or the *Plan* will not consider that course of treatment as *medically necessary* and appropriate for the maximum reimbursement under the *Plan*. The patient is urged to review why there is a discrepancy between what was requested and what was certified before *incurring* charges.

Your *employer* has contracted with the *Medical Management Administrator* in order to assist you in determining whether or not proposed services are appropriate for reimbursement under the *Plan*. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility.

Elements of the Utilization Review Program

The program consists of:

1. **Pre-Certification.** Review of the *medical necessity* for non-emergency services before services are provided.
2. **Retrospective Review.** Review of the *medical necessity* of the health care services provided on an *emergency* basis, after they have been provided.
3. **Concurrent Review.** Ongoing assessment of the health care as it is being provided, especially, but not limited to, *inpatient* confinement in a *hospital* or covered facility (based on the admitting diagnosis and the listed services requested by the attending *physician*).
4. **Discharge Planning.** Certification of services and planning for discharge from a facility or cessation of medical treatment.

Pre-Certification

The provider, patient, or family member must call the *Medical Management Administrator* to receive certification of certain health care management services. This call must be made at least forty-eight (48) hours in advance of services being rendered or within forty-eight (48) hours after an *emergency*.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the out-of-pocket limit.

The following services must be *pre-certified* before the services are provided:

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)

a. surgical and non-surgical (excluding routine vaginal or cesarean deliveries)

b. long term acute care facility (LTAC), not *custodial care*

c. *skilled nursing facility*/rehabilitation facility

d. *inpatient mental health/substance use disorder* treatment (includes *residential treatment facility* services)

The attending *physician* does not have to obtain *pre-certification* from the *Plan* for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

2. *inpatient* and *outpatient surgery*

   Pre-certification is **not** required for the following *surgical procedures*:

   a. office *surgeries*

   b. all colonoscopies and sigmoidoscopies (screening and diagnostic)

   c. elective sterilization procedures

   d. intra-articular hyaluronic acid injections

3. transplant (other than cornea), including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy

4. *adoptive cell therapy*

5. clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening *disease* or condition

   This *Plan* does not cover clinical trials related to other *diseases* or conditions. Refer to the **Medical Benefits** section of this document for a further description and limitations of this benefit.

6. dialysis

7. *durable medical equipment (DME)* in excess of $3,000 (purchase/rental price)

8. *gene therapy*

9. genetic/genomic testing (excluding amniocentesis)

10. *home health care services* (excluding home infusion services)

11. non-emergent air ambulance

12. orthotics/prosthetics in excess of $3,000 (purchase/rental price)

13. *outpatient* advanced imaging (excluding services rendered in an emergency room setting)

    a. computed tomographic (CT) studies

    b. coronary CT angiography

    c. MRI/MRA

    d. nuclear cardiology

    e. nuclear medicine (including SPECT scans)

    f. PET scans

14. *outpatient* physical therapy, occupational therapy, and speech therapy in excess of twenty-five (25) visits per *calendar year* per therapy type

15. partial hospitalization and intensive *outpatient* program in excess of twenty-five (25) visits per *calendar year* per therapy type, for *mental health and substance use disorder* treatment

16. radiation treatments for oncology diagnoses

17. injected, infused, or implanted *prescription drugs* and therapies which are covered under the medical benefits and not obtained through the **Prescription Drug Benefits** (i.e. provided in an *outpatient* facility, physician's office, or home infusion) which are listed at **engage.ameriben.com**

For specialty drugs obtained through the Pharmacy Benefits Manager, please refer to the **Prescription Drug Benefits** section for additional information and requirements for prior authorization.

Services rendered in an emergency room or urgent care setting do not require *pre-certification*.

In order to maximize Plan reimbursements, please read the following provisions carefully.

How to Request Pre-Certification

Before a *plan participant* enters a *medical care facility* on a non-emergency basis or receives other listed medical services, the *Medical Management Administrator* will, in conjunction with the attending *physician*, certify the care as *medically necessary* for *Plan* reimbursement. A non-emergency stay in a *medical care facility* is one that can be scheduled in advance.

The medical management program is set in motion by a telephone call from, or on behalf of, the *plan participant*. Contact the *Medical Management Administrator* **at least forty-eight (48) hours before** services are scheduled to be rendered with the following information:

1. the name of the *plan participant* and relationship to the covered *employee*
2. the name, *employee* identification number, and address of the covered *employee*
3. the name of the *employer*
4. the name and telephone number of the attending *physician*
5. the name of the *medical care facility*
6. the proposed medical services
7. the proposed date(s) of services
8. the proposed length of stay

If there is an *emergency* admission to the *medical care facility*, the patient, patient's family member, *medical care facility*, or attending *physician* must contact the *Medical Management Administrator* within **forty-eight (48) hours** of the first business day after the admission. Refer to the Quick Reference Information Chart for contact information.

The *Medical Management Administrator* will determine the number of days of *medical care facility* confinement or use of other listed medical services authorized for payment.

Warning: Obtaining *pre-certification* of particular services does not guarantee that they will be reimbursed by the *Plan*. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this summary plan description.

NOTE: If your admission or service is determined to **not** be *medically necessary*, you may pursue an *appeal* by following the provisions described in the **Claims and Appeals** section (First Level Appeal of a Pre-Service Claim subsection) of this document. The *plan participant* and provider will be informed of any denial or non-certification in writing.

Penalty for Failure to Pre-Certify

When the required *pre-certification* procedures are followed, your benefits will be unaffected.

Appeals of a Denial of Pre-Certification from the Medical Management Administrator

Pre-certification decisions are considered *claims* decisions that are subject to *appeal*. Refer to the **Claims and Appeals** section (Other Pre-Service Claims subsection) for details on how to *appeal* and the timeframes for appealing a *pre-service claim* decision.

C. Concurrent Review and Discharge Planning

How Concurrent Review Works

Concurrent review of a course of treatment and discharge planning from a *medical care facility* are part of the medical management program. The *Medical Management Administrator* will monitor the *plan participant's medical care facility* stay or use of other medical services and coordinate with the attending *physician*, *medical care facilities*, and *plan participant* either the scheduled release or an extension of the *medical care facility* stay or extension or cessation of the use of other medical services.

If the attending *physician* feels that it is *medically necessary* for a *plan participant* to receive additional services or to stay in the *medical care facility* for a greater length of time than has been *pre-certified*, the attending *physician* must request the additional services or days.

How to File a Concurrent Claim for Benefits under this Plan

Refer to the **Claims and Appeals** section (Concurrent Care Claims subsection) for details on how to *appeal* a denial of a concurrent review. No benefits will be paid for any charges related to days of confinement to a *hospital* or other *health care facility* that have not been determined to be *medically necessary* by the *Medical Management Administrator*.

D. Case Management

Case management is designed to help manage the care of patients who have special or extended care *illnesses* or *injuries*. Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a *plan participant's* health needs, using communication and available resources to promote quality, cost-effective outcomes. The primary objective of case management is to identify and coordinate cost-effective medical care, which meets accepted standards of medical practice. Case management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients, and others.

Cases are identified for possible case management involvement based on a request for review or the presence of a number of parameters, such as, but not limited to:

1. admissions that exceed the recommended or approved length of stay
2. utilization of health care services that generates ongoing and/or excessively high costs
3. conditions that are known to require extensive and/or long-term follow-up care and/or treatment

The *Plan* may elect, at its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the *Plan*. The alternative benefits shall be determined on a case-by-case basis, and the *Plan's* determination to provide the benefits in one (1) instance shall not obligate the *Plan* to provide the same or similar alternative benefits for the same or any other *plan participant*, nor shall it be deemed to waive the right of the *Plan* to strictly enforce the provisions of the *Plan*.

The case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The *Plan Administrator*, attending *physician*, patient, and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the *Plan Administrator* will direct the *Plan* to reimburse for *medically necessary* expenses as stated in the treatment plan, even if these expenses normally would not be paid by the *Plan*. Unless specifically provided to the contrary in the *Plan Administrator's* instructions, reimbursement for expenses *incurred* in connection with the treatment plan shall be subject to all *Plan* limits and cost sharing provisions.

Benefits under case management may be provided if the *Medical Management Administrator* determines that the services are *medically necessary*, appropriate, cost-effective, and feasible. All decisions made by case management are based on the individual circumstances of that *plan participant's* case. Each case is reviewed on its own merits, and any benefits provided are under individual consideration.

All case management is a voluntary service. There are no reductions of benefits or penalties assessed if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

E. Health Management Program

Your *employer* has contracted with AmeriBen Medical Management to provide the Health Management Program. The Health Management Program is designed to assist individuals who are suffering from chronic conditions, or who have been identified as at risk for a chronic condition. The Health Management Program assists *plan participants* with managing those conditions by providing *plan participants* with access to education and personal engagement. This service provides programs for patients to gain education on the care and management of chronic *diseases* (such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), high blood pressure, coronary heart *disease*, etc.) and is designed to improve patient knowledge of the *disease* and techniques for self-management and compliance with proper health care procedures required for the patient's well-being.

How the Health Management Program Works

This program is designed to educate *plan participants* and eligible family members with chronic *diseases* and help *plan participants* better understand and take control of their condition, proactively participate in care and treatment, and reduce the risk of complications. Participation in the program is voluntary and confidential.

Program Benefits:

1. It is a benefit of your health care plan at no extra cost to you.
2. It provides personal contact between you and a specially trained registered nurse (R.N.), who will be your Health Coach.
3. The program supports your *physicians* as well as helping you follow your doctor's plan of care.

This program does not replace *physician*-patient relationships. It is designed to complement the relationship and reinforce the treatment plan of care established by you and your *physician*. All Protected Health Information (PHI) is highly confidential, will be kept confidential as required by law, and shall not be improperly used or disclosed.

Managing Chronic Conditions

Chronic health management is a proactive approach that addresses chronic *diseases* early in the *disease* cycle to prevent *disease* progression and reduce potential health complications. Multiple strategies are used to improve the health of all *plan participants* diagnosed with specific conditions, not only those who visit the provider's office. This approach allows *plan participants* to maintain their independence and remain healthy for as long as possible.

AmeriBen's dedicated team of health management nurses accomplish this by reinforcing proper treatment plans and educating *plan participants* about their conditions. This typically incudes information about:

1. the early signs and symptoms of trouble
2. medications and the proper way to take them
3. following a healthy diet
4. managing and maintaining scheduled doctor visits
5. preventing *hospital* admissions

While the specific list of conditions and programs will vary, the Health Management Program's main goal is to empower the *plan participant* to take control and remain healthy.

How to Enroll

Your *physician* may refer you to the Health Management Program, or you may refer yourself or a covered *dependent* into the program by calling AmeriBen Medical Management directly at 1-888-235-3813 or by visiting **engage.ameriben.com**. *Plan participants* may also be identified through the Predictive Modeling tool. Once you are identified as having a chronic condition, your R.N. health coach will contact you to discuss the next steps of the program.

F. Maternal Health Program

Your *employer* has contracted with Baby Steps, AmeriBen's maternal health program, as part of your healthcare coverage through the IMA Group Health and Flexible Spending Account Plan. This program provides education, support, and a specially trained maternal health nurse who will help you and your baby stay healthy and avoid complications—before, during, and after your *pregnancy*.

How the Maternal Health Program Works

Upon enrolling, your nurse will contact you and ask you a few questions about your *pregnancy*, and you can start receiving the following benefits:

1. a registered nurse (R.N.), who will schedule regular telephone appointments to check on you and your baby
2. access to call your registered nurse with any questions or concerns as often as you like
3. helpful informational and educational *pregnancy* materials
4. help in setting goals, finding a doctor, understanding prenatal tests, and following a safe nutrition and exercise program
5. Upon enrollment, you will receive a FREE copy of the book *What to Expect When You're Expecting*.

Covered *employees*, spouses, and *dependent* children may enroll in the program by contacting Baby Steps directly as shown in the Quick Reference Information Chart.

G. **Tobacco Cessation Program**

Tobacco cessation health coaching, in combination with the Rally Coach DVD program, is an individualized one-on-one program (DVD or online) that is offered to *plan participants* for an additional fee to the *Plan*.

The Tobacco Cessation Program includes the following services:

1. DVD/online programs that allow you the flexibility to participate from the comfort of your own home
2. modules that include educational, empowering, and enjoyable videos and content
3. support through the quitting process from an AmeriBen Registered Nurse Health Coach who will work with your schedule

IMA Financial Group, Inc. will sponsor the cost of the program valued at $350 once per lifetime. Replacement of lost or damaged material will be at the expense of the *participant*. For more information, please contact the wellness coordinator at https://quitnow.net/.

SECTION XI—PRESCRIPTION DRUG BENEFITS

A. About Your Prescription Benefits

The prescription drug benefits are separate from the medical benefits and are administered by CVS through Meritain (PBM Vendor). This program allows you to use your ID card at a nationwide *network* of participating *pharmacies* to purchase your prescriptions. When purchasing *prescription drugs* at retail *pharmacies* or through mail order, using your ID card at participating *pharmacies* provides you with the best economic benefit.

If you purchase your *prescription drugs* from a *non-network pharmacy*, you will have to pay the full price of the prescription and then submit a *claim* for reimbursement. Reimbursement will be according to the *network* price, so your total out-of-pocket cost may likely be greater than the *co-payment* you would have paid if you had used a *network pharmacy*.

Claims for reimbursement of *prescription drugs* are to be submitted to the Pharmacy Benefits Manager at the address listed in the Quick Reference Information Chart.

B. Co-Payments

The *co-payment* is applied to each covered *pharmacy* drug or mail order drug charge and is shown in the applicable Schedule of Prescription Drug Benefits. The *co-payment* amount is not a *covered charge* under the Medical Plan.

C. Co-Insurance

Once you have met the Medical Plan's *calendar year deductible*, your *co-insurance* is applied to each covered *pharmacy* drug or mail order drug charge and is shown in the applicable Schedule of Prescription Drug Benefits.

D. Manufacturer Coupons

Any amounts in the form of manufacturer coupons or drug savings discount cards used for brand name drugs when there is a generic equivalent available, unless the brand name is *medically necessary*, do not apply to the *out-of-pocket limit*.

E. Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart *disease*, high blood pressure, asthma, etc.). Because of volume buying, the mail order *pharmacy*, may be able to offer *plan participants* significant savings on their prescriptions.

F. Tablet Splitting

The tablet splitting program, which is optional for *plan participants*, has identified medications which are taken once daily. The price for a low or high dose tablet is on average the same. Because of this flat pricing of dosage strengths, splitting a tablet of a higher strength to get the desired dose lowers the cost of the medication by up to 50%.

G. Specialty Pharmacy Program

CVS/Caremark Specialty Pharmacy is a specialty pharmacy program offered through a partnership with a specialty *pharmacy* experience in handling specialty drugs. The specialty pharmacy program covers some limited drugs, such as specialty injectables, cancer drugs, and certain respiratory therapies used to treat various chronic conditions. CVS/Caremark Specialty Pharmacy also provides personalized support, education, a proactive refill process, and free delivery, as well as information about health care needs related to the chronic *disease*.

To start using CVS/Caremark Specialty Pharmacy, call toll free at 1-800-237-2767 or visit **www.CVSspecialty.com**.

H. PrudentRx Co-Pay Program for Specialty Medications

In order to provide a comprehensive and cost-effective prescription drug program for *plan participants*, IMA Group Health and Flexible Spending Account Plan has contracted with PrudentRx to offer the PrudentRx Co-Pay Program for certain specialty medications. The PrudentRx Co-Pay Program assists members by helping them enroll in manufacturer co-pay assistance programs.

Co-payment assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Co-Pay Program will assist members in obtaining co-pay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. The PrudentRx patient advocate will help you enroll in the PrudentRx Co-Pay Program and any available manufacturer copay assistance programs. Eligible members who choose to decline enrollment would be responsible for the full amount listed in the applicable Schedule of Prescription Drug Benefits.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Co-Pay Program, you can reach out to PrudentRx or they will proactively contact you. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Co-Pay Program.

The PrudentRx Program Drug List may be updated periodically by the *Plan*.

Co-payments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the *Plan's out-of-pocket maximum*. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Co-Pay Program.

I. Prior Authorization

Prescriptions for certain medications or circumstances require clinical approval before they can be filled, even with a valid prescription. Prescriptions may be limited to quantity, frequency, dosage, or may have age restrictions. The authorization process may be initiated by the *plan participant*, the local *pharmacy*, or the *physician* by calling CVS through Meritain at 1-800-334-8134.

J. Step Therapy Program

Step therapy is a program where you first try a proven, cost-effective medication (called a 'prerequisite drug' in this document) before moving to a more costly drug treatment option. With this program, trying one (1) or more prerequisite drugs is required before a certain prescription medication will be covered under your *pharmacy* benefits plan. Prerequisite drugs are FDA-approved and treat the same condition as the corresponding step therapy drugs. Step therapy promotes the appropriate use of equally effective but lower-cost drugs first. You, your *physician*, or the person you appoint to manage your care can ask for an exception if it is *medically necessary* for you to use a more expensive drug on the step therapy list. If the request is approved, CVS through Meritain will *notify* you or your *physician*. The medication will then be covered at the applicable *co-insurance/co-payment* under your *Plan*. You will also be *notified* of approvals where states require it. If the request is denied, CVS through Meritain will *notify* you and your *physician*. For information on which drugs are part of the step therapy program under your *Plan* call the CVS through Meritain customer service number on your ID card.

K. Medicare Part D Prescription Drug Plans for Medicare Eligible Participants

Plan participants enrolled in either Part A or Part B of *Medicare* are also eligible for *Medicare* Part D Prescription Drug benefits. It has been determined that the *prescription drug* coverage provided in this *Plan* is generally better than the standard *Medicare* Part D *prescription drug* benefits. Because this *Plan's prescription drug* coverage is considered creditable coverage, you do not need to enroll in *Medicare* Part D to avoid a late penalty under *Medicare*. If you enroll in *Medicare* Part D while covered under this *Plan*, payment under this *Plan* may coordinate benefit payment with *Medicare*. Refer to the **Coordination of Benefits** section of the *Plan* for information on how this *Plan* will coordinate benefit payment.

L. Covered Prescription Drug Charges

1. **Abortion.** Drugs that induce abortion such as Mifepristone (RU-486).
2. **Compounded Prescription Drugs.** All compounded *prescription drugs* containing at least one (1) prescription ingredient in a therapeutic quantity.

   For compound drugs to be covered under the *Plan*, they must satisfy certain requirements. In addition to being *medically necessary* and not *experimental/investigational*, compound drugs must not contain any ingredient on a list of excluded ingredients. That list may be obtained from CVS through Meritain. Furthermore, the cost of the compound must be determined by CVS through Meritain to be *reasonable* (e.g. if the cost of any ingredient has increased more than 5% every other week or more than 10% annually), the cost will not be considered *reasonable*. Any denial of coverage a compound drug may be appealed in the same manner as any other drug *claim* denial under the *Plan*.
3. **Diabetic.** Insulin, insulin pump, continuous blood glucose monitor, and glucometer, and other diabetic supplies when prescribed by a *physician*.

   Other injectables are not covered.

   Visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of diabetic supplies related *preventive care* benefits.
4. **Growth Hormones.** Covered only as *medically necessary*.
5. **Impotence.** A charge for impotence medication.
6. **Infertility.** A charge for *infertility* medication.
7. **Injectable Drugs.** Injectable drugs or any prescription directing administration by injection.
8. **Prescribed by Physician.** All drugs prescribed by a *physician* that require a prescription either by federal or state law.

   This excludes any drugs stated as not covered under this *Plan*.
9. **Prescription Drugs Mandated under PPACA.** Certain preventive medications (including contraceptives) received by a *network pharmacy* are covered and subject to the following limitations:
   a. Generic preventive *prescription drugs* are covered at 100%, and the *deductible/co-payment* (if applicable) is waived.
   b. If no *generic drug* is available, then the *formulary brand* will be covered at 100%, and the *deductible/co-payment/co-insurance* (if applicable) is waived.

   This provision includes, but is not limited to, the following categories of drugs (In order for these medications to be covered at 100%, a prescription is required from your *physician*, including over-the-counter drugs.):
   a. **Breast Cancer Risk-Reducing Medications.** Medications such as tamoxifen or raloxifene for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
   b. **Contraceptives**. Women's contraceptives including, but not limited to, oral contraceptives, transdermal contraceptives (i.e., Ortho-Evra), vaginal rings (i.e., Nuvaring), implantable contraceptive devices, injectable contraceptives, and *emergency* contraception.
   c. **Immunizations.** Certain vaccinations are available without cost sharing including vaccines for influenza, pneumonia, tetanus, hepatitis, shingles, measles, mumps, HPV (human papillomavirus),

pertussis, varicella, and meningitis. If the *pharmacy* is *non-network*, those vaccinations will be reimbursable under the medical benefits at 100%.

d. **Tobacco/Vaping Cessation Products**. Such as nicotine gum, smoking deterrent patches, or generic tobacco cessation medications. These drugs are payable without cost sharing up to two (2), twelve (12)-week course of treatment per *calendar year*, which applies to all products. Thereafter, the applicable *co-payment/co-insurance*.

e. **Preparation 'Prep' Products for a Colon Cancer Screening Test.** The *Plan* covers the over-the-counter or prescription strength products prescribed as preparation for a payable preventive colon cancer screening test, such as a colonoscopy.

Please refer to the following website for information on the types of payable preventive medications: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**.

M. Limits to This Benefit

This benefit applies only when a *plan participant incurs* a covered *prescription drug* charge. The covered drug charge for any one (1) prescription will be limited to:

1. refills only up to the number of times specified by a *physician*
2. refills up to one (1) year from the date of order by a *physician*
3. a thirty (30) day supply or ninety (90) day supply for retail prescriptions
4. a ninety (90) day supply for mail-order prescriptions

N. Dispense As Written (DAW) Program

The *Plan* requires that retail *pharmacies* dispense *generic drugs* when available. Should a *plan participant* choose a *formulary* brand or non-preferred *formulary* drug rather than the generic equivalent, the *plan participant* will be responsible for the cost difference between the generic and *formulary* brand or non-preferred *formulary* in addition to the *formulary* brand or non-preferred *formulary* drug *co-payment*, even if a DAW (dispense as written) is written by the prescribing *physician*. The *plan participant's* share of this *prescription drug* cost difference does not apply toward the *Plan's out-of-pocket limit*.

O. Prescription Drug Plan Exclusions

This benefit will not cover a charge for any of the following:

1. **Administration.** Any charge for the administration of a covered *prescription drug*.
2. **Appetite Suppressants/Dietary Supplements.** A charge for appetite suppressants (such as a GLP-1), dietary supplements, or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
3. **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
4. **COVID-19 Home Tests.**
5. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
6. **Drugs Used for Cosmetic Purposes.** Charges for drugs used for *cosmetic* purposes, such as anabolic steroids, Retin A, or medications for hair growth or removal.
7. **Experimental/Investigational.** *Experimental/investigational* drugs and medicines, even though a charge is made to the *plan participant*. A drug or medicine labeled: "Caution: Federal law prohibits dispensing without prescription."
8. **FDA.** Any drug not approved by the Food and Drug Administration.

9. **Immunization.** Immunization agents or biological sera.
10. **Inpatient Medication.** A drug or medicine that is to be taken by the *plan participant*, in whole or in part, while *hospital* confined. This includes being confined in any *institution* that has a facility for the dispensing of drugs and medicines on its premises.
11. **Medical Exclusions.** A charge excluded under the Medical Plan Exclusions subsection, unless specifically covered in this **Prescription Drug Benefits** section.
12. **No Charge.** A charge for *prescription drugs* which may be properly received without charge under local, state, or federal programs.
13. **Non-Legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
14. **Over-the-Counter Drugs.** Charges for over-the-counter drugs or medicines, regardless of whether purchased on the advice of a *physician*, unless required by law. A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
15. **Refills.** Any refill that is requested more than one (1) year after the prescription was written or any refill that is more than the number of refills ordered by the *physician*.

P. Claims and Appeals

Prescription drug claims and *appeals* are managed by the Pharmacy Benefits Manager. Please contact the Pharmacy Benefits Manager as listed in the Quick Reference Information Chart for additional information.

SECTION XII—CLAIMS AND APPEALS

Please refer to the *Plan's* wrap document.

A. Designation of Authorized Representative

A *plan participant* is permitted to appoint an *authorized representative* to act on behalf of the *plan participant* with respect to a benefit *claim* or *appeal* of a denial. Neither a HIPAA authorization nor an *assignment of benefits* by a *plan participant* to a provider will constitute appointment of that provider as an *authorized representative*. To appoint such a representative, the *plan participant* must submit the authorization in writing or complete a form which can be obtained from the *Plan Administrator* or the *Third Party Administrator*. The form must clearly indicate on the form the nature and extent of the authorization. In connection with a *claim* involving urgent care, the *Plan* will permit a health care professional with knowledge of the *plan participant's* medical condition to act as the *plan participant's authorized representative*. In the event a *plan participant* designates an *authorized representative*, all future communications from the *Plan* will be with the representative, rather than the *plan participant*, unless the *plan participant* directs the *Plan Administrator*, in writing, to the contrary. If you wish to change/alter your authorized representative, or the time frame, you will need to submit these changes in writing.

B. Physical Examinations

The *Plan* reserves the right to have a *physician* of its own choosing examine any *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. All such examinations shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan* may reasonably require during the pendency of a *claim*. The *plan participant* must comply with this requirement as a necessary condition to coverage.

C. Autopsy

The *Plan* reserves the right to have an autopsy performed upon any deceased *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. This right may be exercised only where not prohibited by law.

D. Payment of Benefits

All benefits under this *Plan* are payable, in U.S. dollars, to the *plan participant* whose *illness* or *injury*, or whose covered *dependent's illness* or *injury*, is the basis of a *claim*. In the event of the death or incapacity of a *plan participant*, and in the absence of written evidence to this *Plan* of the qualification of a guardian for their estate, this *Plan* may, in its sole discretion, make any and all such payments to the individual or *institution* which, in the opinion of this *Plan*, is or was providing the care and support of such *employee*.

E. Assignments

Benefits for medical expenses covered under this *Plan* may be assigned by a *plan participant* to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the *employee*, the *Plan* shall be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the *plan participant* and the assignee, has been received before the proof of loss is submitted.

No *plan participant* shall at any time, either during the time in which they are a *plan participant* in the *Plan*, or following their termination as a *plan participant*, in any manner, have any right to assign their right to sue to recover benefits under the *Plan*, to enforce rights due under the *Plan*, or to any other causes of action which they may have against the *Plan* or its fiduciaries.

A provider which accepts an *assignment of benefits*, in accordance with this *Plan* as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

F. Non-U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (non-U.S. provider) are payable under the *Plan*, subject to all *Plan* exclusions, limitations, maximums, and other provisions, under the following conditions:

1. Benefits may not be assigned to a non-U.S. provider.
2. The *plan participant* is responsible for making all payments to non-U.S. providers and submitting receipts to the *Plan* for reimbursement.
3. Benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date.
4. The non-U.S. provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements.
5. *Claims* for benefits must be submitted to the *Plan* in English.

G. Recovery of Payments

Occasionally, benefits are paid more than once; are paid based upon improper billing or a misstatement in a proof of loss or enrollment information; are not paid according to the *Plan's* terms, conditions, limitations, or exclusions; or should otherwise not have been paid by the *Plan*. As such, this *Plan* may pay benefits that are later found to be greater than the *maximum allowable charge*. In this case, this *Plan* may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the *plan participant* or *dependent* on whose behalf such payment was made.

A *plan participant*, *dependent*, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the *Plan* within thirty (30) days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a *plan participant* or other entity does not comply with the provisions of this section, the *Plan Administrator* shall have the authority, in its sole discretion, to deny payment of any *claims* for benefits by the *plan participant* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the *Plan* or to whom a right to benefits has been assigned, in consideration of services rendered, payments, and/or rights, agrees to be bound by the terms of this *Plan* and agree to submit *claims* for reimbursement in strict accordance with their state's health care practice acts, ICD-10 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator* or insurer. Any payments made on *claims* for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within thirty (30) days of discovery or demand or *incur* prejudgment interest of 1.5% per month. If the *Plan* must bring an action against a *plan participant*, provider, or other person or entity to enforce the provisions of this section, then that *plan participant*, provider, or other person or entity agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

Further, *plan participants* and/or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns (*plan participant*) shall assign or be deemed to have assigned to the *Plan* their right to recover said payments made by the *Plan*, from any other party and/or recovery for which the *plan participant(s)* are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the *Plan* has not already been refunded.

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

1. in error
2. pursuant to a misstatement contained in a proof of loss or a fraudulent act
3. pursuant to a misstatement made to obtain coverage under this *Plan* within two (2) years after the date such coverage commences
4. with respect to an ineligible person
5. in anticipation of obtaining a recovery if a *plan participant* fails to comply with the *Plan's* **Reimbursement, Subrogation, and Recovery Provisions**
6. pursuant to a *claim* for which benefits are recoverable under any policy or act of law providing for coverage for occupational *injury* or *disease* to the extent that such benefits are recovered

   This provision (6) shall not be deemed to require the *Plan* to pay benefits under this *Plan* in any such instance.

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

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

SECTION XIII—COORDINATION OF BENEFITS

A. Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of *covered charges* when two (2) or more plans, including *Medicare*, are paying. When a *plan participant* is covered by this *Plan* and another plan, or the *plan participant's* spouse is covered by this *Plan* and by another plan, or the couple's covered children are covered under two (2) or more plans, the plans will coordinate benefits when a *claim* is received.

Standard Coordination of Benefits (COB)

The plan that pays first according to the rules will pay as if there were no *other plan* involved. The secondary and subsequent plans will pay the balance due up to 100% of the total *allowable charges* and apply the benefits of the *Plan*.

Example: Assume all *deductibles* are met, billed services are considered *covered charges* under both plans, the primary plan pays 80% of the *allowable amount*, and the secondary plan pays 90% of the *allowable amount*. A *plan participant* incurs a *claim* with a *network* provider in which the *allowable amount* is $1,000.

Primary Plan	$800
Secondary Plan	$200
Patient Responsibility	$0
Total Amount Paid	$1,000

B. Excess Insurance

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

The *Plan's* benefits will be excess to, whenever possible:

1. any primary payer besides the *Plan*
2. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured or underinsured motorist coverage
3. any policy of insurance from any insurance company or guarantor of a third party
4. workers' compensation or other liability insurance company
5. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payment

C. Allowable Charge

For a charge to be allowable it must be within the *Plan's maximum amount* and at least part of it must be covered under this *Plan*.

In the case of HMO (health maintenance organization) or other *network* only plans, this *Plan* will not consider any charges in excess of what an HMO or *network* provider has agreed to accept as payment in full. Also, when an HMO or *network* plan is primary and the *plan participant* does not use an HMO or *network* provider, this *Plan* will not consider as an *allowable charge* any charge that would have been covered by the HMO or *network* plan had the *plan participant* used the services of an HMO or *network* provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the *allowable charge*.

D. General Limitations

When medical payments are available under any other insurance source, the *Plan* shall always be considered the secondary carrier.

E. Application to Benefit Determinations

The plan that pays first according to the rules in the subsection entitled Benefit Plan Payment Order will pay as if there were no *other plan* involved. The secondary and subsequent plans will pay the balance due up to 100% of the total *allowable charges*.

When there is a conflict in the rules, this *Plan* will never pay more than 50% of *allowable charges* when paying secondary. Benefits will be coordinated as referenced in the Claims Determination Period subsection.

When medical payments are available under automobile insurance, this *Plan* will pay excess benefits only, without reimbursement for automobile plan *deductibles*. This *Plan* will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the *other plan* will be ignored for the purposes of determining the benefits under this *Plan*. This is the case when either:

1. the *other plan* would, according to its rules, determine its benefits after the benefits of this *Plan* have been determined
2. the rules in the subsection entitled Benefit Plan Payment Order would require this *Plan* to determine its benefits before the *other plan*

F. Benefit Plan Payment Order

When two (2) or more plans provide benefits for the same *allowable charge*, benefit payment will adhere to these rules in the following order:

1. Plans that do not have a coordination provision, or one like this, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the *allowable charge*:
    a. The benefits of the plan which covers the person directly (that is, as an *employee*, member, or subscriber) are determined before those of the plan which covers the person as a *dependent*.
    b. The benefits of a benefit plan which covers a person as an *employee* who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired *employee*. The benefits of a benefit plan which covers a person as a *dependent* of an *employee* who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a *dependent* of a laid off or retired *employee*. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
    c. The benefits of a benefit plan which covers a person as an *employee* who is neither laid off nor retired or a *dependent* of an *employee* who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
    d. When a child is covered as a *dependent* and the parents are not separated or divorced, these rules will apply:
        i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year.
        ii. If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
    e. When a *child's* parents are divorced or legally separated, these rules will apply:

i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the *child* as a *dependent* will be considered next. The benefit plan of the parent without custody will be considered last.

iii. This rule will be in place of items (i.) and (ii.) immediately above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before *other plans* that cover the child as a *dependent*.

iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of *benefit determination* rules outlined above when a child is covered as a *dependent* and the parents are not separated or divorced.

v. For parents who were never married to each other, the rules apply as set out above, as long as paternity has been established.

f. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the *Plan* will never pay more than 50% of *allowable charges* when paying secondary.

g. When a married *dependent* child is covered as a *dependent* on both a spouse's plan and a parent's plan, and the policies are both effective on the same day, the benefits of the policy holder whose birthday falls earlier in a year are determined before those of the policy holder whose birthday falls later in that year.

3. *Medicare* will pay primary, secondary, or last to the extent stated in federal law. Refer to the *Medicare* publication Your Guide to Who Pays First at **https://www.medicare.gov/publications/02179-Medicare-and-other-health-benefits-your-guide-to-who-pays-first.pdf**. When *Medicare* would be the primary payer if the person had enrolled in *Medicare*, this *Plan* will base its payment upon benefits that would have been paid by *Medicare* under Parts A and B, regardless of whether or not the person was enrolled under any of these parts. The *Plan* reserves the right to coordinate benefits with respect to *Medicare* Part D. The *Plan Administrator* will make this determination based on the information available through Centers for Medicare & Medicaid Services (CMS). If CMS does not provide sufficient information to determine the amount *Medicare* would pay, the *Plan Administrator* will make *reasonable* assumptions based on published *Medicare* fee schedules.

4. If a *plan participant* is under a disability extension from a previous benefit plan, that benefit plan will pay first, and this *Plan* will pay second.

5. When an adult *dependent* is covered by their spouse's plan and is also covered by a parent's plan, the benefits of the benefit plan which has covered the patient for the longest time are determined before those of the *other plan*.

6. When an adult *dependent* is covered by multiple parents' plans, the benefits of the benefit plan of the parent whose birthday falls earlier in the year are determined before those of the benefit plan of the parent whose birthday falls later in that year. Should both/all parents have the same birthday, the benefits of the benefit plan which has covered the patient the longest shall be determined first.

7. The *Plan* will pay primary to Tricare and a state *Children's Health Insurance Program* to the extent required by federal law.

G. Coordination with Government Programs

1. **Medicaid/IHS.** If a *plan participant* is covered by both this *Plan* and Medicaid or Indian Health Services (IHS), this *Plan* pays first and Medicaid or IHS pays second.

2. **Veterans Affairs or Military Medical Facility Services.** If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military-service-related *illness* or *injury*, benefits are not covered by this *Plan*. If a *plan participant* receives services in a U.S.

Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military-service-related *illness* or *injury*, benefits are covered by the *Plan* to the extent those services are *medically necessary* and the charges are within this *Plan's maximum allowable charge*.

3. **Other Coverage Provided by State or Federal Law.** If you are covered by both this *Plan* and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this *Plan* pays second, unless applicable law dictates otherwise.

H. Claims Determination Period

Benefits will be coordinated on a *calendar year* basis. This is called the claims determination period.

I. Right to Receive or Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any *other plan*, this *Plan* may, without the consent of or *notice* to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the *Plan* deems to be necessary for such purposes. Any person claiming benefits under this *Plan* shall furnish to the *Plan* such information as may be necessary to implement this provision.

J. Facility of Payment

Whenever payments which should have been made under this *Plan* in accordance with this provision have been made under any *other plans*, the *Plan Administrator* may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this *Plan* and, to the extent of such payments, this *Plan* shall be fully discharged from liability. This *Plan* may repay *other plans* for benefits paid that the *Plan Administrator* determines it should have paid. That repayment will count as a valid payment under this *Plan*.

K. Right of Recovery

In accordance with the **Claims and Appeals** section, Recovery of Payments subsection, whenever payments have been made by this *Plan* with respect to *allowable charges* in a total amount, at any time, in excess of the *maximum amount* of payment necessary at that time to satisfy the intent of this article, the *Plan* shall have the right to recover such payments, to the extent of such excess, from any one (1) or more of the following as this *Plan* shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the *Plan* determines are responsible for payment of such *allowable charges*, and any future benefits payable to the *plan participant* or their *dependents*. Please see the Recovery of Payments subsection for more details.

L. Exception to Medicaid

In accordance with ERISA, the *Plan* shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the *Plan* or making a determination about the payments for benefits received by a *plan participant* under the *Plan*.

SECTION XIV—MEDICARE

A. Application to Active Employees and Their Spouses

An active *employee* and their spouse (when eligible for *Medicare*) may, at the option of such *employee*, elect or reject coverage under this *Plan*. If such *employee* elects coverage under this *Plan*, the benefits of this *Plan* shall be determined before any benefits provided by *Medicare*. If coverage under this *Plan* is rejected by such *employee*, benefits listed herein will not be payable even as secondary coverage to *Medicare*.

B. Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by federal regulations, this *Plan* will pay before any *Medicare* benefits. There are some circumstances under which *Medicare* would be required to pay its benefits first. In these cases, benefits under this *Plan* would be calculated as the secondary payer (as described under the section entitled **Coordination of Benefits**). The *plan participant* will be assumed to have full *Medicare* coverage (that is, both Parts A & B) whether or not the *plan participant* has enrolled for the full coverage. If the provider accepts assignment with *Medicare*, *covered charges* will not exceed the *Medicare* approved expenses.

SECTION XV—REIMBURSEMENT, SUBROGATION, AND RECOVERY PROVISIONS

These **Reimbursement, Subrogation, and Recovery Provisions** apply when the *Plan* pays benefits as a result of *injuries* or *illnesses* the *plan participant* sustained, and the *plan participant* has a right to a recovery or have received a recovery from any source.

A. Definitions

As used in these **Reimbursement, Subrogation, and Recovery Provisions**, '*plan participant'* includes anyone on whose behalf the *Plan* pays benefits. These **Reimbursement, Subrogation, and Recovery Provisions** apply to all current or former *plan participants* and *Plan* beneficiaries. The provisions also apply to the parents, guardian, or other representative of a *dependent* child who incurs *claims* and is or has been covered by the *Plan.* The *Plan's* rights under these provisions shall also apply to the personal representative or administrator of the *plan participant's* estate, the *plan participant's* heirs or beneficiaries, minors, and legally incompetent or disabled persons. If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative shall be subject to these **Reimbursement, Subrogation, and Recovery Provisions**. Likewise, if the covered person's relatives, heirs, and/or assignees make any recovery because of *injuries* sustained by the covered person, or because of the death of the covered person, that recovery shall be subject to this provision, regardless of how any recovery is allocated or characterized.

As used in these **Reimbursement, Subrogation, and Recovery Provisions**, 'recovery' includes, but is not limited to, monies received from any person or party; any person's or party's liability insurance coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers' compensation insurance or fund, premises medical payments coverage, restitution, or "no-fault" or personal *injury* protection insurance and/or automobile medical payments coverage; or any other first- or third-party insurance coverage, whether by lawsuit, settlement, or otherwise. Regardless of how the *plan participant* or the *plan participant's* representative or any agreements allocate or characterize the money the *plan participant* receives as a recovery, it shall be subject to these provisions.

B. Subrogation

Immediately upon paying or providing any benefit under the *Plan*, the *Plan* shall be subrogated to, or stand in the place of, all of the *plan participant's* rights of recovery with respect to any *claim* or potential *claim* against any party, due to an *injury*, *illness,* or condition to the full extent of benefits provided or to be provided by the *Plan.* The *Plan* has the right to recover payments it makes on the *plan participant's* behalf from any party or insurer responsible for compensating the *plan participant* for the *plan participant's illnesses* or *injuries*. The *Plan* has the right to take whatever legal action it sees fit against any person, party, or entity to recover the benefits paid under the *Plan*. The *Plan* may assert a *claim* or file suit in the *plan participant's* name and take appropriate action to assert its subrogation *claim*, with or without the *plan participant's* consent. The *Plan* is not required to pay the *plan participant* part of any recovery it may obtain, even if it files suit in the *plan participant's* name.

C. Reimbursement

If the *plan participant* receives any payment as a result of an *injury*, *illness,* or condition, the *plan participant* agrees to reimburse the *Plan* first from such payment for all amounts the *Plan* has paid and will pay as a result of that *injury*, *illness,* or condition, up to and including the full amount of the *plan participant's* recovery. If the *plan participant* obtains a recovery and the *Plan* has not been repaid for the benefits the *Plan* paid on the *plan participant's* behalf, the *Plan* shall have a right to be repaid from the recovery in the amount of the benefits paid on the *plan participant's* behalf. The *plan participant* must promptly reimburse the *Plan* from any recovery to the extent of benefits the *Plan* paid on the *plan participant's* behalf regardless of whether the payments the *plan participant* receives makes the *plan participant* whole for the *plan participant's* losses, *illnesses,* and/or injuries.

D. Secondary to Other Coverage

The *Plan* shall be secondary in coverage to any medical payments provision, *no-fault automobile insurance* policy, or personal *injury* protection policy regardless of any election made by the *plan participant* to the contrary. The *Plan*

shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

E. Assignment

In order to secure the *Plan's* rights under these **Reimbursement, Subrogation, and Recovery Provisions**, The *plan participant* agrees to assign to the *Plan* any benefits or *claims* or rights of recovery the *plan participant* has under any automobile policy or other coverage, to the full extent of the *Plan's* subrogation and reimbursement *claims*. This assignment allows the *Plan* to pursue any *claim* the *plan participant* may have regardless of whether the *plan participant* chooses to pursue the *claim*.

F. Applicability to All Settlements and Judgments

Notwithstanding any allocation or designation of the *plan participant's* recovery made in any settlement agreement, judgment, verdict, release, or court order, the *Plan* shall have a right of full recovery, in first priority, against any recovery the *plan participant* makes. Furthermore, the *Plan's* rights under these **Reimbursement, Subrogation, and Recovery Provisions** will not be reduced due to the *plan participant's* own negligence. The terms of these **Reimbursement, Subrogation, and Recovery Provisions** shall apply and the *Plan* is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the terms of any settlement, judgment, or verdict pertaining to the *plan participant's* recovery identify the medical benefits the *Plan* provided or purport to allocate any portion of such recovery to payment of expenses other than medical expenses. The *Plan* is entitled to recover from any recovery, even those designated as being for pain and suffering, non-economic damages, and/or general damages only.

G. Constructive Trust

By accepting benefits from the *Plan*, the *plan participant* agrees that if the *plan participant* receives any payment as a result of an *injury*, *illness,* or condition, the *plan participant* will serve as a constructive trustee over those funds. The *plan participant* and the *plan participant's* legal representative must hold in trust for the *Plan* the full amount of the recovery to be paid to the *Plan* immediately upon receipt. Failure to hold such funds in trust will be deemed a breach of the *plan participant's fiduciary* duty to the *Plan*. Any recovery the *plan participant* obtains must not be dissipated or disbursed until such time as the *Plan* has been repaid in accordance with these **Reimbursement, Subrogation, and Recovery Provisions**.

H. Lien Rights

The *Plan* will automatically have a lien to the extent of benefits paid by the *Plan* for the treatment of the *plan participant's illness*, *injury,* or condition upon any recovery related to treatment for any *illness*, *injury,* or condition for which the *Plan* paid benefits. The lien may be enforced against any party who possesses funds or proceeds from the *plan participant's* recovery including, but not limited to, the *plan participant*, the *plan participant's* representative or agent, and/or any other source possessing funds from the *plan participant's* recovery. The *plan participant* and the *plan participant's* legal representative acknowledge that the portion of the recovery to which the *Plan's* equitable lien applies is a *Plan* asset. The *Plan* shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the *Plan's* lien and/or to obtain (or preclude the transfer, dissipation, or disbursement of) such portion of any recovery in which the *Plan* may have a right or interest.

I. First-Priority Claim

By accepting benefits from the *Plan*, the *plan participant* acknowledges the *Plan's* rights under these **Reimbursement, Subrogation, and Recovery Provisions** are a first-priority *claim* and are to be repaid to the *Plan* before the *plan participant* receives any recovery for the *plan participant's* damages. The *Plan* shall be entitled to full reimbursement on a first-dollar basis from any recovery, even if such payment to the *Plan* will result in a recovery which is insufficient to make the *plan participant* whole or to compensate the *plan participant* in part or in whole for the losses, injuries, or *illnesses* the *plan participant* sustained. The "made-whole" rule does not apply. To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the *Plan's* subrogation *claim* and any *claim* held by the *plan participant*, the *Plan's* subrogation *claim* shall be first satisfied before any part of a recovery is applied to the

plan participant's claim, the *plan participant's* attorney fees, other expenses or costs. The *Plan* is not responsible for any attorney fees, attorney liens, other expenses, or costs the *plan participant incurs*. The common fund doctrine does not apply to any funds recovered by any attorney the *plan participant* hires regardless of whether funds recovered are used to repay benefits paid by the *Plan*.

J. Cooperation

The *plan participant* agrees to cooperate fully with the *Plan's* efforts to recover benefits paid. The duty to cooperate includes, but is not limited, to the following:

1. The *plan participant* must promptly *notify* the *Plan* of how, when, and where an *accident* or incident resulting in personal *injury* or *illness* to the *plan participant* occurred, all information regarding the parties involved, and any other information requested by the *Plan*.
2. The *plan participant* must *notify* the *Plan* within thirty (30) days of the date when any *notice* is given to any party, including an insurance company or attorney, of the *plan participant's* intention to pursue or investigate a *claim* to recover damages or obtain compensation due to the *plan participant's injury*, *illness,* or condition.
3. The *plan participant* must cooperate with the *Plan* in the investigation, settlement, and protection of the *Plan's* rights. In the event that the *plan participant* or the *plan participant's* legal representative fails to do whatever is necessary to enable the *Plan* to exercise its subrogation or reimbursement rights, the *Plan* shall be entitled to deduct the amount the *Plan* paid from any future benefits under the *Plan*.
4. The *plan participant* and the *plan participant's* agents shall provide all information requested by the *Plan*, the *Claims Administrator,* or its representative, including, but not limited to, completing and submitting any applications or other forms or statements as the *Plan* may reasonably request and all documents related to or filed in personal *injury* litigation.
5. The *plan participant* recognizes that to the extent that the *Plan* paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the *reasonable* value of those payments or the actual paid amount, whichever is higher.
6. The *plan participant* must not do anything to prejudice the *Plan's* rights under these **Reimbursement, Subrogation, and Recovery Provisions**. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the *Plan*.
7. The *plan participant* must send the *Plan* copies of all police reports, *notices,* or other papers received in connection with the *accident* or incident resulting in personal *injury* or *illness* to the *plan participant*.
8. The *plan participant* must promptly *notify* the *Plan* if the *plan participant* retains an attorney or if a lawsuit is filed on the *plan participant's* behalf.
9. The *plan participant* must immediately *notify* the *Plan* if a trial is commenced, if a settlement occurs, or if potentially dispositive motions are filed in a case.

In the event that the *plan participant* or the *plan participant's* legal representative fails to do whatever is necessary to enable the *Plan* to exercise its rights under these **Reimbursement, Subrogation, and Recovery Provisions**, the *Plan* shall be entitled to deduct the amount the *Plan* paid from any future benefits under the *Plan*.

If the *plan participant* fails to repay the *Plan*, the *Plan* shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the *Plan* has paid or the amount of the *plan participant's* recovery, whichever is less, from any future benefit under the *Plan* if either of the following apply:

1. The amount the *Plan* paid on the *plan participant's* behalf is not repaid or otherwise recovered by the *Plan*.
2. The *plan participant* fails to cooperate.

In the event the *plan participant* fails to disclose the amount of the *plan participant's* settlement to the *Plan*, the *Plan* shall be entitled to deduct the amount of the *Plan's* lien from any future benefit under the *Plan*.

The *Plan* shall also be entitled to recover any of the unsatisfied portion of the amount the *Plan* has paid or the amount of the *plan participant's* recovery, whichever is less, directly from the providers to whom the *Plan* has made payments on the *plan participant's* behalf. In such a circumstance, it may then be the *plan participant's* obligation to pay the provider the full billed amount, and the *Plan* will not have any obligation to pay the provider or reimburse the *plan participant*.

The *plan participant* acknowledges the *Plan* has the right to conduct an investigation regarding the *injury*, *illness,* or condition to identify potential sources of recovery. The *Plan* reserves the right to *notify* all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

The *plan participant* acknowledges the *Plan* has notified the *plan participant* that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share the *plan participant's* personal health information in exercising these **Reimbursement, Subrogation, and Recovery Provisions**.

The *Plan* is entitled to recover its attorney's fees and costs incurred in enforcing its rights under these **Reimbursement, Subrogation, and Recovery Provisions**.

K. Discretion

The *Plan* Administrator has sole discretion to interpret the terms of the **Reimbursement, Subrogation, and Recovery Provisions** of this *Plan* in its entirety and reserves the right to make changes as it deems necessary.

SECTION XVI—CONTINUATION COVERAGE RIGHTS UNDER COBRA

Please refer to the *Plan's* wrap document.

SECTION XVII—FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the *Plan* is funded as follows:

A. For Employee and Dependent Coverage

Funding is derived from the funds of the *employer* and contributions made by the covered *employees*.

The level of any *employee* contributions will be set by the *Plan Administrator*. These *employee* contributions will be used in funding the cost of the *Plan* as soon as practicable after they have been received from the *employee* or withheld from the *employee's* pay through payroll deduction.

Benefits are paid directly from the *Plan* through the *Third Party Administrator*.

Payment for Coverage

The specific amount you must pay for coverage is announced each *benefit year*. You pay your contributions for medical coverage on a **before-tax** basis. This means that your payments for these coverages come from your pay before federal, and in most cases, state taxes are withheld. That way, you should pay less in taxes.

The amount and frequency of that contribution is determined by IMA Financial Group, Inc. (within permissible government guidelines) and announced on an annual basis.

NOTE: If you elect coverage for a domestic partner and that domestic partner is not your tax-qualified *dependent*, the contributions you make toward the cost of this domestic partner coverage must be deducted on an after-tax basis, in accordance with IRS regulations. The amount your *employer* pays toward the cost of your domestic partner coverage must be imputed as income and therefore is taxable to you, the *employee*. If you have questions about the tax implications of covering a domestic partner, contact your financial or tax advisor. **IMA Financial Group, Inc. does not provide tax advice, and nothing in this paragraph should be construed as providing tax advice.**

B. Clerical Error

Any clerical error by the *Plan Administrator* or an agent of the *Plan Administrator* in keeping pertinent records, or a delay in making any changes, will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a *Plan* reimbursement amount, the *Plan* retains a contractual right to the overpayment. The person or *institution* receiving the overpayment will be required to return the amount paid in error. In the case of a *plan participant*, the amount of overpayment may be deducted from future benefits payable.

SECTION XVIII—CERTAIN PLAN PARTICIPANTS' RIGHTS UNDER ERISA

Please refer to the *Plan's* wrap document.

SECTION XIX—FEDERAL NOTICES

A. Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

An *employee* or *dependent* who is eligible, but not enrolled in this *Plan*, may enroll if:

1. The *employee* or *dependent* is covered under a Medicaid plan under Title XIX of the Social Security Act or a state Children's Health Insurance Program (CHIP) under Title XXI of such Act, and coverage of the *employee* or *dependent* is terminated due to loss of eligibility for such coverage, and the *employee* or *dependent* requests enrollment in this *Plan* within sixty (60) days after such Medicaid or CHIP coverage is terminated.
2. The *employee* or *dependent* becomes eligible for assistance with payment of *employee* contributions to this *Plan* through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the *employee* or *dependent* requests enrollment in this *Plan* within sixty (60) days after the date the *employee* or *dependent* is determined to be eligible for such assistance.

If a *dependent* becomes eligible to enroll under this provision and the *employee* is not then enrolled, the *employee* must enroll in order for the *dependent* to enroll.

B. Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA generally prohibits discrimination in group premiums based on *genetic information* and the use of *genetic information* as a basis for determining eligibility or setting premiums, and places limitations on genetic testing and the collection of *genetic information* in group health plan coverage. GINA provides clarification with respect to the treatment of *genetic information* under privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

C. Mental Health Parity and Addiction Equity Act of 2008

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and *mental health* or *substance use disorder* benefits, such plan or coverage shall ensure all of the following:

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

Regardless of any limitations on benefits for *mental disorders/substance use disorder* treatment otherwise specified in the *Plan*, any aggregate lifetime limit, annual limit, financial requirement, *non-network* exclusion, or treatment limitation on *mental disorders/substance use disorder* benefits imposed by the *Plan* shall comply with federal parity requirements, if applicable.

D. Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

Please refer to the *Plan's* wrap document.

E. Non-Discrimination Policy

This *Plan* will not discriminate against any *plan participant* based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This *Plan* will not establish rules for eligibility based on health status, medical condition, *claims* experience, receipt of health care, medical history, evidence of insurability, *genetic information*, or disability.

This *Plan* intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986. If the *Plan Administrator* determines before or during any *plan year* that this *Plan* may fail to satisfy any non-discrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the *Plan Administrator* shall take such action as the *Plan Administrator* deems appropriate, under rules uniformly applicable to similarly situated covered *employees*, to assure compliance with such requirements or limitation.

F. Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Employees going into or returning from military service may elect to continue *Plan* coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) under the following circumstances. These rights apply only to *employees* and their *dependents* covered under the *Plan* immediately before leaving for military service.

1. The maximum period of coverage of a person and the person's *dependents* under such an election shall be the lesser of:
    a. the twenty-four (24) month period beginning on the date on which the person's absence begins
    b. the day after the date on which the person was required to apply for or return to a position of employment and fails to do so
2. A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the *Plan*, except a person on active duty for thirty (30) days or less cannot be required to pay more than the *employee's* share, if any, for the coverage.
3. An exclusion or *waiting period* may not be imposed in connection with the reinstatement of coverage upon re-employment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or *waiting period* may be imposed for coverage of any *illness* or *injury* determined by the Secretary of Veterans Affairs to have been *incurred* in, or aggravated during, the performance of *uniformed service*.

If the *employee* wishes to elect this coverage or obtain more detailed information, contact the *Plan Administrator* as outlined in the Quick Reference Information Chart. The *employee* may also have continuation rights under *USERRA*. In general, the *employee* must meet the same requirements for electing *USERRA* coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The *employee* may elect *USERRA* continuation coverage for the *employee* and their *dependents*. Only the *employee* has election rights. *Dependents* do not have any independent right to elect *USERRA* health plan continuation.

Please also refer to the *Plan's* wrap document.

G. Women's Health and Cancer Rights Act of 1998 (WHCRA)

Please refer to the *Plan's* wrap document.

SECTION XX—COMPLIANCE WITH HIPAA PRIVACY STANDARDS

A. Compliance with HIPAA Privacy Standards

Please refer to the *Plan's* wrap document.

B. Certification of Employer.

Please refer to the *Plan's* wrap document.

1. The following members of IMA Financial Group, Inc.'s workforce are designated as authorized to receive Protected Health Information from IMA Group Health and Flexible Spending Account Plan (*Plan*) in order to perform their duties with respect to the *Plan*:
    a. Director of Corporate Benefits (Privacy Office)
    b. Director of Benefits Administration

    Please also refer to the *Plan's* wrap document.

C. Compliance with HIPAA Electronic Security Standards

Please refer to the *Plan's* wrap document.

SECTION XXI—DEFINED TERMS

The following terms have special meanings and will be italicized when used in this *Plan*. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

Accident

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

Active Employment

Performance by the *employee* of all the regular duties of their occupation at an established business location of the participating *employer*, or at another location to which they may be required to travel to perform the duties of their employment. An *employee* shall be deemed actively at work if the *employee* is absent from work due to a health factor. In no event will an *employee* be considered actively at work if they have effectively terminated employment.

Adoptive Cell Therapy

A type of immunotherapy in which T cells (a type of immune cell) are given to a patient to help the body fight diseases, such as cancer. In cancer therapy, T cells are usually taken from the patient's own blood or tumor tissue, grown in large numbers in the laboratory, and then given back to the patient to help the immune system fight the cancer. Sometimes, the T cells are changed in the laboratory to make them better able to target the patient's cancer cells and kill them. Types of adoptive cell therapy include, but not limited to, chimeric antigen receptor T-cell (CAR T-cell) therapy and tumor-infiltrating lymphocyte (TIL) therapy. Also called adoptive cell transfer, *cellular adoptive immunotherapy*, and T-cell transfer therapy.

Adverse Benefit Determination

Any of the following: a denial, reduction, rescission, or termination of a *claim* for benefits, or a failure to provide or make payment for such a *claim* (in whole or in part), including determinations of a *claimant's* eligibility, the application of any review under the Health Care Management Program, and determinations that an item or service is *experimental/investigational* or not *medically necessary* or appropriate.

Allowable Charges

The *maximum amount/maximum allowable charge* for any *medically necessary*, eligible item of expense, at least a portion of which is covered under a plan. When some *other plan* pays first in accordance with the Application to Benefit Determinations subsection in the **Coordination of Benefits** section herein, this *Plan's* allowable charges shall in no event exceed the *other plan's* allowable charges. When some *other plan* provides benefits in the form of services rather than cash payments, the *reasonable* cash value of each service rendered, in the amount that would be payable in accordance with the terms of the *Plan*, shall be deemed to be the benefit. Benefits payable under any *other plan* include the benefits that would have been payable had *claim* been duly made therefore.

Alternate Recipient

Any child of a *plan participant* who is recognized under a *medical child support order* as having a right to enrollment under this *Plan* as the *plan participant's* eligible *dependent*. For purposes of the benefits provided under this *Plan*, an alternate recipient shall be treated as an eligible *dependent*, but for purposes of the reporting and disclosure requirements under ERISA, an alternate recipient shall have the same status as a *plan participant*.

Ambulatory Surgical Center

A licensed facility that is used mainly for performing *outpatient surgery*, has a staff of *physicians*, has continuous *physician* and nursing care by registered nurses (R.N.s), and does not provide for overnight stays.

Appeal

A review by the *Plan* of an *adverse benefit determination*, as required under the *Plan's* internal *claims* and appeals procedures.

Applied Behavioral Analysis (ABA) Therapy

Applied Behavioral Analysis (ABA) Therapy is an umbrella term describing principles and techniques used in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors. The goal of ABA Therapy is to teach new skills, promote generalization of these skills, and reduce challenging behaviors with systematic reinforcement. ABA Therapy is a combination of services for adaptive behavior treatment, which applies the principles of how people learn and motivations to change behavior. ABA Therapy is designed to address multiple areas of behavior and function such as to increase language and communication, enhance attention and focus, and help with social skills and memory. It generally includes psychosocial interventions, should address factors that may exacerbate behavioral challenges, and is most effective when initiated as soon as feasible after diagnosis is made.

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is described in **any** of the following subparagraphs:

1. The study or investigation is approved or funded by one (1) 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 and Medicaid Services
    e. a cooperative group or center of any of the entities described in sub-clauses a. through d. above, 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. any of the following if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by *qualified individuals* who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs
        ii. The Department of Defense
        iii. The Department of Energy
2. The study or investigation is conducted under an *investigational* new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an *investigational* new drug application.

Assignment of Benefits

An arrangement by which a patient may request that their health benefit payments under this *Plan* be made directly to a designated medical provider or facility. By completing an assignment of benefits, the *plan participant* authorizes the *Plan Administrator* to forward payment for a covered procedure directly to the treating medical provider or facility. The *Plan Administrator* expects an assignment of benefits form to be completed, as between the *plan participant* and the provider.

Authorized Representative

An authorized representative is a person or organization a *plan participant* has designated to act on their behalf to submit or *appeal* a *claim*. By authorizing a person or organization to act on your behalf, you are giving them permission to see your Protected Health Information (PHI) and act on all matters related to your *claim* and/or *appeal*. If you choose to authorize a person to act on your behalf, all future communications shall be with the designee. Where an *urgent care claim* is involved, a health care professional with knowledge of

the medical condition will be permitted to act as a *claimant's* authorized representative without a prior written authorization.

Balance Bill/Surprise Bill

Balance bill refers to the difference between a *non-network provider's* total billed charges and the *allowable charges* off of which the *Plan* will base its reimbursement.

Non-network providers have no obligation to accept the *allowable charge* as payment in full. You are responsible to pay a *non-network provider's* billed charges, even though the *Plan's* reimbursement is based on the *allowable charge*. Any amounts paid for balance bills do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

Benefit Determination

The *Plan's* decision regarding the acceptance or denial of a *claim* for benefits under the *Plan*.

Benefit Year

The twelve (12) month period beginning January 1 and ending December 31. All *deductibles* and benefit maximums accumulate during the benefit year.

Birthing Center

Any freestanding health facility, place, professional office, or *institution* which is not a *hospital* or in a *hospital*, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.

The birthing center must provide the following:

1. facilities for obstetrical delivery and short-term recovery after delivery
2. care under the full-time supervision of a *physician* and either a registered nurse (R.N.) or a licensed nurse-midwife
3. have a written agreement with a *hospital* in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement

Blue Distinction Center/Blue Distinction Center+

Blue Distinction Center (BDC) Facility: Blue Distinction facilities have met or exceeded national quality standards for care delivery (quality only).

Blue Distinction Center+ (BDC+) Facility: Blue Distinction+ facilities have met or exceeded national quality standards for care delivery AND have demonstrated that they operate more efficiently (quality and cost).

See also *Center of Excellence*.

Brand Name

A trade name medication.

Calendar Year/Benefit Year

January 1st through December 31st of the same year. All *deductibles* and benefit maximums accumulate during the calendar year.

Cellular Immunotherapy

A type of therapy that uses substances to stimulate or suppress the immune system to help the body fight cancer, infection, and other diseases. Some types of immunotherapy only target certain cells of the immune system. Others affect the immune system in a general way. Types of immunotherapy include cytokines, vaccines, bacillus Calmette-Guerin (BCG), and some monoclonal antibodies.

Claim

Any request for a *Plan* benefit, made by a *claimant* or by a representative of a *claimant*, in accordance with a *Plan's* reasonable procedure for filing benefit claims.

Some requests made to the *Plan* are specifically not claims for benefits; for example:

1. an inquiry as to eligibility which does not request benefits
2. a request for prior approval where prior approval is not required by the *Plan*
3. casual inquiries about benefits such as verification of whether a service/item is a covered benefit or the estimated cost for a service

Claimant

Any *plan participant* or beneficiary making a *claim* for benefits. Claimants may file *claims* themselves or may act through an *authorized representative*. In this document, the words 'you' and 'your' are used interchangeably with 'claimant.'

Claims Administrator

See *Third Party Administrator* and refer to the *Plan's* wrap document.

Clean Claim

A *claim* that can be processed in accordance with the terms of this summary plan description without obtaining additional information from the service provider or a third party. It is a *claim* which has no defect, impropriety, or special circumstance that delays *timely payment*. A clean *claim* does not include:

1. *claims* under investigation for fraud and abuse
2. *claims* under review for *medical necessity*
3. fees under review for *usual and customariness* and *reasonableness*
4. any other matter that may prevent the expense(s) from being considered a *covered charge*

The claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A *claim* will not be considered to be a clean claim if the *participant* has failed to submit required forms or additional information to the *Plan* as well.

Co-Insurance

The portion of medical expenses (after the *deductible* has been satisfied) for which the *plan participant* and/or *Plan* is responsible.

Concurrent Care Claim

A *Plan* decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

Co-Payment

A specific dollar amount a *plan participant* is required to pay and is typically payable to the health care provider at the time services or supplies are rendered.

Cosmetic

Procedures are considered cosmetic when intended to change a physical appearance that would be considered within normal human anatomic variation. Cosmetic services are often described as those that are primarily intended to preserve or improve appearance.

Cost Sharing Amounts

The dollar amount a *plan participant* is responsible for paying when covered services are received from a provider. Cost sharing amounts include *co-insurance*, *co-payments*, *deductible* amounts, and *out-of-pocket*

limits. Providers may bill you directly or request payment of *co-insurance* and/or *co-payments* at the time services are provided. Refer to the applicable Schedules of Benefits for the specific cost sharing amounts that apply to this *Plan*.

Courtesy Review

A pre-service review of requested services for benefits which are neither on the pre-certification list nor an exclusion of the *Plan*.

Covered Charges

The *maximum allowable charge* for a *medically necessary* service, treatment, or supply meant to improve a condition or *plan participant's* health, which is eligible for coverage in this *Plan*. Covered charges will be determined based upon all other *Plan* provisions. When more than one (1) treatment option is available, and one (1) option is no more effective than another, the covered charge is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the applicable Schedule of Medical Benefits section and as determined elsewhere in this document.

Custodial Care

Care (including *room and board* needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of custodial care include help in walking and getting out of bed, assistance in bathing, dressing, feeding, or supervision over medication which could normally be self-administered.

Deductible

A specified portion of the *covered charges* that must be *incurred* by a *plan participant* before the *Plan* has any liability.

Dentist

A person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent

For information regarding eligibility for dependents, refer to the section entitled **Eligibility, Effective Date, and Termination Provisions**.

Developmental Delay

A delay in the appearance of normal developmental milestones achieved during infancy and early childhood, caused by organic, psychological, or environmental factors. Conditions are marked by delayed development or functional limitations especially in learning, language, communication, cognition, behavior, socialization, or mobility.

Diagnosis Related Grouping (DRG)

A method for reimbursing *hospitals* for *inpatient* services. A DRG amount can be higher or lower than the actual billed charge because it is based on an average for that grouping of diagnoses and procedures.

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a *disease* or condition. It must be ordered by a *physician* or other professional provider.

Disease

Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the *Plan* is furnished showing that the individual concerned is covered as an *employee* under any workers' compensation law, occupational disease law, or any other legislation of similar purpose, or under the maritime

doctrine of maintenance, wages, and cure, but that the disorder involved is one (1) not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the *Plan*, be regarded as a *sickness*, *illness*, or disease.

Durable Medical Equipment (DME)

Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an *illness* or *injury*, and is appropriate for use in the home.

Emergency

A situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An emergency includes poisoning, shock, and hemorrhage. Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the *Plan*, that an emergency did exist. The *Plan* may, at its own discretion, request satisfactory proof that an emergency or acute condition did exist.

Emergency Medical Condition

A medical condition of recent onset and severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Emergency Services

A medical screening examination [as required under Section 1867 of the Social Security Act (EMTALA)] within the capability of the *hospital* emergency department, including routine ancillary services, to evaluate a *medical emergency* and such further medical examination and treatment as are within the capabilities of the staff and facilities of the *hospital* and required under EMTALA to stabilize the patient.

Employee

Please refer to the *Plan's* wrap document.

Employer

Please refer to the *Plan's* wrap document.

Enrollment Date

The first day of coverage or, if there is a *waiting period*, the first day of the *waiting period*.

Essential Health Benefits

Benefits set forth under the *Patient Protection and Affordable Care Act of 2010* (*PPACA*), including the categories listed in the state of Utah benchmark plan.

Experimental/Investigational

Services, supplies, care, and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The *Plan Administrator* must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The *Plan Administrator* shall be guided by a reasonable interpretation of *Plan* provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the *claim* and the proposed treatment. The decision of the *Plan Administrator* will be final and binding on the *Plan*. The *Plan Administrator* will be guided by the following principles, any of which comprise a definition of experimental/investigational:

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

2. if the drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval
3. if reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis
4. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis

   'Reliable evidence' shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility, or the protocols of another facility studying substantially the same drug, service, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Benefits covered under the Clinical Trials provision are not considered experimental or investigational.

The *Plan Administrator* has the discretion to determine which drugs, services, supplies, care, and/or treatments are considered experimental, investigational, or unproven.

Explanation of Benefits (EOB)

A document sent to the *plan participant* by the *Third Party Administrator* after a *claim* for reimbursement has been processed. It includes the patient's name, claim number, type of service, provider, date of service, charges submitted for the services, amounts covered by this *Plan*, non-covered services, *cost sharing amounts*, and the amount of the charges that are the *plan participant's* responsibility. This form should be carefully reviewed and kept with other important records.

External Review

A review of an *adverse benefit determination*, including a *final internal adverse benefit determination*, under applicable state or federal external review procedures.

Family Unit

The covered *employee* and the family members who are covered as *dependents* under the *Plan*.

Fiduciary

A fiduciary exercises discretionary authority or control over management of the *Plan* or the disposition of its assets, renders investment advice to the *Plan*, or has discretionary authority or responsibility in the administration of the *Plan*.

Final Internal Adverse Benefit Determination

An *adverse benefit determination* that has been upheld by the *Plan* at completion of the *Plan's* internal *appeals* procedures; or an *adverse benefit determination* for which the internal *appeals* procedures have been exhausted under the deemed exhausted rule contained in the *appeals* regulations. For plans with two (2) levels of *appeals*, the second-level *appeal* results in a final internal *adverse benefit determination* that triggers the right to *external review*.

FMLA Leave

Please refer to the *Plan's* wrap document.

Formulary

A list of prescription medications compiled by the third-party payer of safe and effective therapeutic drugs specifically covered by this *Plan*.

Foster Child

A child under the limiting age shown in the **Eligibility, Effective Date, and Termination Provisions** section of this *Plan* for whom a covered *employee* has assumed a legal obligation in connection with the child's placement with a state, county, or private foster care agency.

A covered foster child is not a child temporarily living in the covered *employee's* home; one placed in the covered *employee's* home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Gene Therapy

Human gene therapy seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use. It is a technique that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms:

1. replacing a disease-causing gene with a healthy copy of the gene
2. inactivating a disease-causing gene that is not functioning properly
3. introducing a new or modified gene into the body to help treat a disease

Generic Drug

A *prescription drug* which has the equivalency of the *brand name* drug with the same use and metabolic disintegration. This *Plan* will consider as a generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information

Information about the genetic tests of an individual or their family members and information about the manifestations of *disease* or disorder in family members of the individual. A genetic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, which detects genotypes, mutations, or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested *disease*, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

The *Plan* complies with Title I of the Genetic Information Nondiscrimination Act of 2008 (GINA) as it applies to group health plans.

Habilitative Services/Habilitation Services

Habilitative services are intended to maintain, develop, or improve skills needed to perform activities of daily living (ADLs) or instrumental activities of daily living (IADLs) which have not (but normally would have) developed or which are at risk of being lost as a result of *illness*, *injury*, loss of a body part, or congenital abnormality.

Health Savings Account (HSA)

A tax-exempt or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you *incur*. You must be eligible to qualify for an HSA (refer to the **Schedule of Benefits** section of this document). Both *employer* and *employee* may contribute to an *HSA* in the same year. Annual contribution limits are subject to IRS guidelines. Participation in a qualified *high deductible health plan* is required for participation in an *HSA* program.

High Deductible Health Plan (HDHP)

A medical plan with lower premiums and a minimum *deductible* amount set forth by federal law which is higher than a traditional health plan *deductible*.

Home Health Care Agency

An organization that meets all of these tests: its main function is to provide *home health care services and supplies*; it is federally certified as a home health care agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan

Must meet these tests: it must be a formal written plan made by the patient's attending *physician* which is reviewed at least every thirty (30) days; it must state the diagnosis; it must certify that the home health care is in place of *hospital* confinement; and it must specify the type and extent of *home health care services and supplies* required for the treatment of the patient.

Home Health Care Services and Supplies

Includes part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a *home health care agency* (this does not include general housekeeping services); physical, occupational, and speech therapy; medical supplies; and laboratory services by or on behalf of the *hospital*.

Hospice Care Agency

An organization whose main function is to provide *hospice care services and supplies* and is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan

A plan of terminal patient care that is established and conducted by a *hospice care agency* and supervised by a *physician*.

Hospice Care Services and Supplies

Provided through a *hospice care agency* and under a *hospice care plan* and includes *inpatient* care in a *hospice unit* or other licensed facility, and home health care, and family counseling during the bereavement period.

Hospice Unit

A facility or separate *hospital* unit that provides treatment under a *hospice care plan* and admits at least two (2) unrelated persons who are expected to die within six (6) months.

Hospital (Acute or Long-Term Acute Care Facility)

A provider licensed and operated as required by law, which provides all of the following and is fully accredited by The Joint Commission:

1. room, board, and nursing care
2. a staff with one (1) or more doctors on hand at all times
3. twenty-four (24) hour nursing service
4. all the facilities on site are needed to diagnose, care, and treat an *illness* or *injury*

The term hospital does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. *custodial care*
6. educational care
7. subacute care

Refer to the defined terms for *Residential Treatment Facility* and *Substance Use Disorder/Mental Health Treatment Center* for the specific requirements applicable to those facility types.

Illness

A bodily disorder, congenital defects, *disease*, physical illness, or *mental disorder*. Includes *pregnancy*, childbirth, miscarriage, or complications of *pregnancy*.

Incurred

An expense for a service or supply is incurred on the date the service or supply is furnished. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Review Organization (IRO)

An entity that performs independent *external reviews* of *adverse benefit determinations* and *final internal adverse benefit determinations*.

Infertility

Incapable of producing offspring.

Injury

An *accidental bodily injury*, which does not arise out of, which is not caused or contributed by, and which is not a consequence of, any employment or occupation for compensation or profit.

In-Network

See *Network*.

Inpatient

Treatment in an approved facility during the period when charges are made for *room and board*.

Institution

A facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a *hospital*, *ambulatory surgical center*, *psychiatric hospital*, community *mental health* center, *residential treatment facility*, psychiatric treatment facility, *substance use disorder treatment center*, alternative *birthing center*, home health care center, or any other such facility that the *Plan* approves.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a *hospital* solely for the care and treatment of patients who are critically *ill*. This also includes what is referred to as a coronary care unit or an acute care unit. It has facilities for special nursing care not available in regular rooms and wards of the *hospital*; special lifesaving equipment which is immediately available at all times; at least two (2) beds for the accommodation of the critically *ill*; and at least one (1) registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Investigational

See *Experimental/Investigational*.

Late Enrollee

Please refer to the *Plan's* wrap document.

Leave of Absence

A period of time during which the *employee* does not work, but which is of a stated duration, after which time the *employee* is expected to return to active work. Please also refer to the *Plan's* wrap document.

Legal Guardian

A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Life-Threatening Disease or Condition

Any *disease* or condition from which the likelihood of death is probable unless the course of the *disease* is interrupted.

Long Term Acute Care Hospitals

Facilities that specialize in the treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures.

Long Term Care

Generally refers to non-medical care for patients who need assistance with basic daily activities such as dressing, bathing, and using the bathroom. Long-term care may be provided at home or in facilities that include nursing homes and assisted living.

Maintenance Care

Therapy or treatment intended primarily to maintain general physical condition, including, but not limited to routine, long-term, or maintenance care which is provided after the resolution of an acute medical problem. This includes services performed solely to preserve the present level of function or prevent regression for an *illness*, *injury*, or condition that is resolved or stable.

Mastectomy

The surgical removal of all or part of a breast.

Maximum Amount or Maximum Allowable Charge

The benefit payable for a specific coverage item or benefit under the *Plan*. Maximum allowable charge(s) will be based on one (1) of the following options, depending on the circumstances of the *claim* and at the discretion of the *Plan Administrator*:

1. *network* allowed amount
2. *network non-participating provider* rate
3. 125% of the *Medicare* rate for *outpatient* dialysis *claims*
4. 110% of the *Medicare* rate for *non-network claims*

   If there is not a Medicare-like rate available, or if a claim is considered under the Special Reimbursement Provisions, the non-network claim will be priced at 90% of the usual and customary and/or reasonable amount.
5. the negotiated rate established in a contractual arrangement with a provider
6. the *usual and customary* and/or *reasonable* amount
7. the actual billed charges for the covered services

The maximum allowed amount for emergency care from a *non-network* provider will be determined using the median *Plan network* contract rate paid to *network* providers for the geographic area where the service is provided.

The *Plan* has the discretionary authority to decide if a *charge* is *usual and customary* and/or *reasonable* for a *medically necessary* service. The maximum allowable charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Maximum Benefit

Any one (1) of the following, or any combination of the following:

1. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* during the entire time they are covered by this *Plan*
2. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* for a particular *covered charge*

   The *maximum amount* can be for either of the following:

   a. the entire time the *plan participant* is covered under this *Plan*
   b. a specified period of time, such as a *calendar year*

3. the maximum number as outlined in the *Plan* as a *covered charge*

   The maximum number relates to the number of:

   a. treatments during a specified period of time
   b. days of confinement
   c. visits by a *home health care agency*

Medical Care Facility

A *hospital*, a facility that treats one (1) or more specific ailments, or any type of *skilled nursing facility*.

Medical Child Support Order

Any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that mandates one (1) of the following:

1. provides for child support with respect to a *plan participant's* child or directs the *plan participant* to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law)
2. enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan

Medical Management Administrator

A team of medical care professionals selected to conduct *pre-certification* review, *emergency* admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the **Health Care Management Program** section of this document.

Medical Non-Emergency Care

Care which can safely and adequately be provided other than in a *hospital*.

Medically Necessary/Medical Necessity

Care and treatment which is recommended or approved by a *physician*; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a *physician* recommends or approves certain care does not mean that it is medically necessary.

The *Plan Administrator* has the discretionary authority to decide whether care or treatment is medically necessary.

Medicare

The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder and Nervous Disorders/Substance Use Disorder

Any *disease* or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and

Human Services, or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

Mental Health or Substance Use Disorder Hold

An involuntary detainment, by an officer of the court, in an *inpatient facility*, of an individual who is either posing a danger to themselves or others or determined to be gravely disabled due to a mental health condition. Typically lasting up to seventy-two (72) hours.

Morbid Obesity

Severity of obesity judged appropriate for procedure, as indicated by one (1) or more of the following:

1. adult patient has BMI of thirty-five (35) or greater
2. adolescent patient [thirteen (13) to seventeen (17) years of age] has BMI of forty (40) (or 140% of the 95th percentile in age and sex matched growth chart) or greater
3. adult patient has BMI of thirty (30) or greater and a clinically serious condition related to obesity (e.g. type 2 diabetes, obesity hypoventilation, obstructive sleep apnea, nonalcoholic steatohepatitis, pseudotumor cerebri, severe osteoarthritis, difficult to control hypertension)
4. adolescent patient [thirteen (13) to seventeen (17) years of age] has BMI of thirty-five (35) (or 120% of the 95th percentile in an age and sex matched growth chart) or greater and a clinically serious condition related to obesity [e.g. type 2 diabetes, obstructive sleep apnea, nonalcoholic steatohepatitis, pseudotumor cerebri, Blount disease (tibia vara), slipped capital femoral epiphysis]
5. adult patient has BMI of thirty (30) or greater with type 2 diabetes mellitus with inadequately controlled hyperglycemia despite optimal medical treatment (e.g. oral medication, insulin)
6. as outlined in the *Medical Management Administrator's medical necessity* criteria in use at the time of a morbid obesity *surgical procedure*

Network

An arrangement under which services are provided to *plan participants* through a select group of providers.

No-Fault Auto Insurance

The basic reparations provision of a law providing for payments without determining fault in connection with automobile *accidents*.

Non-Network

Services rendered by a *non-participating provider* within the designated *network* area.

Non-Participating Provider

A health care practitioner or health care facility that has not contracted directly with the *Plan*, *network*, or an entity contracting on behalf of the *Plan* to provide health care services to *plan participants*.

Notice/Notify/Notification

The delivery or furnishing of information to a *claimant* as required by federal law.

Open Enrollment Period

The annual period during which you and your *dependents* are eligible to enroll for coverage or change benefit plan options.

Other Plan

Shall include but is not limited to:

1. any primary payer besides the *Plan*
2. any other group health plan
3. any other coverage or policy covering the *plan participant*

4. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured, or underinsured motorist coverage
5. any policy of insurance from any insurance company or guarantor of a responsible party
6. any policy of insurance from any insurance company or guarantor of a third party
7. workers' compensation or other liability insurance company
8. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payment

Out-of-Network

See *Non-Network*.

Out-of-Pocket Limit

A *Plan's* limit on the amount a *plan participant* must pay out of their own pocket for medical expenses *incurred* during a *calendar year*. Out-of-pocket limits accumulate on an individual, family, or combined basis. After a *plan participant* reaches the out-of-pocket limit, the *Plan* pays benefits at a higher rate.

Outpatient

Treatment including services, supplies, and medicines provided and used at a *hospital* under the direction of a *physician* to a person not admitted as a registered bed patient; or services rendered in a *physician's* office, laboratory, or X-ray facility, *ambulatory surgical center*, or the patient's home.

Participating Provider

A health care provider or health care facility that has contracted directly with the *Plan* or an entity contracting on behalf of the *Plan* to provide health care services to *plan participants*.

Patient Protection and Affordable Care Act of 2010 (PPACA)

The Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Jointly, these laws are referred to as PPACA.

Pharmacy

A licensed establishment where covered *prescription drugs* are filled and dispensed by a pharmacist licensed under the laws of the state where they practice.

Physician

A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of their license.

Plan

Please refer to the *Plan's* wrap document.

Plan Administrator

IMA Financial Group, Inc., which is the named *fiduciary* of the *Plan*, and exercises all discretionary authority and control over the administration of the *Plan* and the management and disposition of *Plan* assets. Please also refer to the *Plan's* wrap document.

Plan Participant/Participant

Any *employee* or *dependent* who is covered under this *Plan*.

Plan Sponsor

Please refer to the *Plan's* wrap document.

Post-Service Claim

Any *claim* for a benefit under the *Plan* related to care or treatment that the *plan participant* or beneficiary has already received.

Pre-Admission Tests/Testing

Those *diagnostic services* done prior to scheduled *surgery*, provided that all of the following conditions are met:

1. The tests are approved by both the *hospital* and the *physician*.
2. The tests are performed on an *outpatient* basis prior to *hospital* admission.
3. The tests are performed at the *hospital* into which confinement is scheduled, or at a qualified facility designated by the *physician* who will perform the *surgery*.

Pre-Certification/Pre-Certified

An evaluation conducted by a utilization review team through the Health Care Management Program to determine the *medical necessity* and *reasonableness* of a *plan participant's* course of treatment.

Pregnancy

Childbirth and conditions associated with pregnancy, including complications.

Prescription Drug

Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed *physician*. Such drug must be *medically necessary* in the treatment of an *illness* or *injury*.

Pre-Service Claim

Any *claim* that requires *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* (e.g. a request for *pre-certification* under the **Health Care Management Program**).

Preventive Care

Certain preventive services mandated under the *Patient Protection and Affordable Care Act of 2010 (PPACA)* which are available without cost sharing when received from a *network* provider. To comply with *PPACA*, and in accordance with the recommendations and guidelines, the *Plan* will provide *network* coverage for:

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

Copies of the recommendations and guidelines may be found here:
https://www.healthcare.gov/coverage/preventive-care-benefits/ or
http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

For more information, you may contact the *Plan Administrator/employer* as outlined in the Quick Reference Information Chart.

Primary Care Physician (PCP)

Family practitioners, general practitioners, internists, midwives, naturopaths, OBGYNs, and pediatricians.

Charges from nurse practitioners and physician's assistants will be considered at the level of the provider they bill under.

Prior Plan

The coverage provided on a group or group-type basis by the group insurance policy, benefit plan, or service plan that was terminated on the day before the effective date of the *Plan* and replaced by the *Plan*.

Prior to Effective Date or After Termination Date

Dates occurring before a *plan participant* gains eligibility from the *Plan*, or dates occurring after a *plan participant* loses eligibility from the *Plan*, as well as charges *incurred* prior to the effective date of coverage under the *Plan* or after coverage is terminated, unless extension of benefits applies.

Privacy Standards

The standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

Psychiatric Hospital

An *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospitals*, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally *ill* persons either by, or under the supervision of, a *physician*.
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided.
3. It is licensed as a psychiatric hospital.
4. It requires that every patient be under the care of a *physician*.
5. It provides twenty-four (24) hour per day nursing service.

The term psychiatric hospital does not include an *institution*, or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care*, or educational care.

Qualified Individual

An individual who is a covered *participant* or beneficiary in this *Plan* and who meets the following conditions:

1. the individual is eligible to participate in an *approved clinical trial* according to the trial protocol with respect to the treatment of cancer or other *life-threatening disease or condition*; and
2. either:
    a. The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.
    b. The *participant* or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.

Qualified Medical Child Support Order (QMCSO)

Please refer to the *Plan's* wrap document.

Reasonable

In the *Plan Administrator's* discretion, services, supplies, or fees for services or supplies which are necessary for the care and treatment of *illness* or *injury* not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the *Plan Administrator*, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular

service or supply; industry standards, and practices as they relate to similar scenarios; and the cause of *injury* or *illness* necessitating the services and/or charges.

This determination will consider, but will not be limited to, the findings and assessments of the following entities:

1. The National Medical Associations, societies, and organizations
2. The Food and Drug Administration

To be reasonable, services and/or fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care, and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The *Plan Administrator* retains discretionary authority to determine whether services and/or fees are reasonable based upon information presented to the *Plan Administrator*. A finding of provider negligence and/or malpractice is not required for services and/or fees to be considered not reasonable.

Charges and/or services are not considered to be reasonable, and as such are not eligible for payment (exceed the *maximum allowable charge*), when they result from provider errors and/or facility-acquired conditions deemed reasonably preventable through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The *Plan* reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the *Plan* and to identify charges and/or services that are not reasonable and therefore not eligible for payment by the *Plan*.

Reconstructive/Reconstruction

Procedures are considered reconstructive when intended to address a significant variation from normal related to accidental *injury*, *disease*, trauma, treatment of a *disease*, or a congenital defect.

Rehabilitation Hospital

An *institution* which mainly provides therapeutic and restorative services to *ill* or *injured* people. It is recognized as such if it meets the following criteria:

1. It carries out its stated purpose under all relevant federal, state, and local laws.
2. It is accredited for its stated purpose by either The Joint Commission or the Commission on Accreditation for Rehabilitation Facilities.

Rehabilitation Services/Rehabilitative Services

Rehabilitative services are intended to improve, adapt, or restore functions which have been impaired or permanently lost as a result of *illness*, *injury*, loss of a body part, or congenital abnormality involving goals an individual can reach in a reasonable period of time. Benefits will end when treatment is no longer medically necessary and the individual stops progressing toward those goals.

Residential Treatment Center/Facility

A provider licensed and operated as required by law, which includes:

1. *room*, *board*, and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight (8) hours daily with twenty-four (24) hour availability
2. a staff with one (1) or more doctors available at all times
3. residential treatment takes place in a structured facility-based setting
4. the resources and programming to adequately diagnose, care, and treat a psychiatric and/or substance use disorder
5. facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care
6. is fully accredited by one of the following:
    i. the Joint Commission (TJC)
    ii. the Commission on Accreditation of Rehabilitation Facilities (CARF)

iii. the National Integrated Accreditation for Healthcare Organizations (NIAHO)

iv. the Council on Accreditation (COA)

v. Healthcare Facilities Accreditation Program (HFAP)

vi. DNV GL Healthcare (DNV)

vii. the Center for Improvement in Healthcare Quality (CIHQ)

The term residential treatment center/facility does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. *custodial care*
6. educational care

Room and Board

A *hospital's* charge for:

1. room and linen service
2. dietary service, including meals, special diets, and nourishment
3. general nursing service
4. other conditions of occupancy which are *medically necessary*

Security Standards

The final rule implementing HIPAA's security standards for the Protection of Electronic PHI, as amended.

Sickness

See *Disease*.

Skilled Nursing Facility

A facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an *inpatient* basis to persons recovering from an *injury* or *illness*. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a *physician*.
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, *custodial care*, or educational care.

This term also applies to charges *incurred* in a facility referring to itself as an extended acute rehabilitation facility, *long-term acute care facility*, or any other similar nomenclature.

Sound Natural Tooth

A tooth that is stable, functional, free from decay and advanced periodontal *disease*, and in good repair at the time of the *accident*.

Spinal Manipulation/Chiropractic Care

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

Substance Use Disorder/Mental Health Treatment Center

An *institution* which provides a program for the treatment of *substance use disorder* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be at least one (1) of the following:

1. affiliated with a *hospital* under a contractual agreement with an established system for patient referral
2. accredited as such a facility by The Joint Commission or CARF
3. licensed, certified, or approved as an alcohol or *substance use disorder* treatment program center, *psychiatric hospital*, or *facility* for *mental health* by a state agency having legal authority to do so
4. is a facility operating primarily for the treatment of *substance use disorder* and meets these tests:
    a. maintains permanent and full-time facilities for bed care and full-time confinement of at least twenty-four (24) hour-per-day nursing service by a registered nurse (R.N.)
    b. has a full-time psychiatrist or psychologist on the staff
    c. is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of *substance use disorder*

Substance Use Disorder

The DSM-5 definition is applied as follows: Substance use disorder describes a problematic pattern of using alcohol or another substance (whether obtained legally or illegally) that results in impairment in daily life or noticeable distress. An individual must display two (2) of the following eleven (11) symptoms within twelve (12) months:

1. consuming more alcohol or other substance than originally planned
2. worrying about stopping or consistently failed efforts to control one's use
3. spending a large amount of time using drugs/alcohol, or doing whatever is needed to obtain them
4. use of the substance results in failure to fulfill major role obligations such as at home, work, or school
5. craving the substance (alcohol or drug)
6. continuing the use of a substance despite health problems caused or worsened by it

    This can be in the domain of *mental health* (psychological problems may include depressed mood, sleep disturbance, anxiety, or blackouts) or physical health.
7. continuing the use of a substance despite its having negative effects in relationships with others (for example, using even though it leads to fights or despite people's objecting to it)
8. repeated use of the substance in a dangerous situation (for example, when having to operate heavy machinery, when driving a car)
9. giving up or reducing activities in a person's life because of the drug/alcohol use
10. building up a tolerance to the alcohol or drug

    Tolerance is defined by the DSM-5 as either needing to use noticeably larger amounts over time to get the desired effect or noticing less of an effect over time after repeated use of the same amount.
11. experiencing withdrawal symptoms after stopping use

    Withdrawal symptoms typically include, according to the DSM-5: anxiety, irritability, fatigue, nausea/vomiting, hand tremor, or seizure in the case of alcohol.

Surgery/Surgical Procedure

Any of the following:

1. the incision, excision, debridement, or cauterization of any organ or part of the body and the suturing of a wound
2. the manipulative reduction of a fracture or dislocation or the manipulation of a joint, including application of cast or traction
3. the removal by endoscopic means of a stone or other foreign object from any part of the body, or the diagnostic examination by endoscopic means of any part of the body
4. the induction of artificial pneumothorax and the injection of sclerosing solutions
5. arthrodesis, paracentesis, arthrocentesis, and all injections into the joints or bursa
6. obstetrical delivery and dilatation and curettage
7. biopsy
8. surgical injection

Temporomandibular Joint (TMJ)

The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves, and other tissues related to the temporomandibular joint.

Third Party Administrator

AmeriBen has been hired as the Third Party Administrator by the *Plan Administrator* to perform *claims* processing and other specified administrative services in relation to the *Plan*. The Third Party Administrator is not an insurer of health benefits under this *Plan*, is not a *fiduciary* of the *Plan*, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*. The Third Party Administrator is not responsible for *Plan* financing and does not guarantee the availability of benefits under this *Plan*.

Timely Payment

As referenced in the section entitled **Continuation Coverage Rights Under COBRA**. Timely payment means a payment made no later than thirty (30) days after the first day of the coverage period.

Total Disability/Totally Disabled

In the case of a *dependent* child, the complete inability, as a result of *injury* or *illness*, to perform the normal activities of a person of like age and sex and in good health.

Uniformed Services

The Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the President of the United States in time of war or *emergency*.

Urgent Care Claim

Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an urgent care claim will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any *claim* that a *physician* with knowledge of the *claimant's* medical condition determines is an urgent care claim as described herein shall be treated as an urgent care claim under the *Plan*. Urgent care claims are a subset of *pre-service claims*.

Urgent Care Facility

A free-standing facility, regardless of its name, at which a *physician* is in attendance at all times that the facility is open, that is engaged primarily in providing minor *emergency* and episodic medical care to a *plan participant*.

Usual and Customary Charge

Covered charges which are identified by the *Plan Administrator*, taking into consideration the fees which the provider most frequently charges (or accepts) for the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same area by providers of similar training and experience for the service or supply, and the *Medicare* reimbursement rates. The term(s) 'same geographic locale' and/or 'area' shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons, or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be usual and customary, fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

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

The term 'customary' refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one (1) individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale.

The term 'usual and customary' does not necessarily mean the actual charge made (or accepted), nor the specific service or supply furnished to a *plan participant* by a provider of services or supplies, such as a *physician*, therapist, nurse, *hospital*, or pharmacist. The *Plan Administrator* will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service, or supply is customary.

Usual and customary charges may, at the *Plan Administrator's* discretion, alternatively be determined and established by the *Plan* using normative data such as, but not limited to, *Medicare* cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer's retail pricing (MRP) for supplies and devices.

Waiting Period

An interval of time during which the *employee* is in the continuous, *active employment* of their participating *employer*.