SUMMARY PLAN DESCRIPTION

This SPD is approved by employer for use as the final form of the SPD.

By: Robert Arnold (Dec 4, 2023 16:18 CST) **Date:** Dec 4, 2023

Celarity Gravie Comfort $4,000 OOPM Medical Option

GRAVIE ADMINISTRATIVE SERVICES

December 2023

Questions?	**Gravie Administrative Services Customer Service staff is available to answer questions about *your* coverage Monday through Friday from 8AM to 5PM Central Time.** **Customer Service: 866.863.6232**
	When contacting Customer Service, please have *your* identification card available. If *your* questions involve a bill, we will need to know the date of service, type of service, the name of the *provider* and the charges involved.
Telephone Numbers for Utilization Management Vendor for Pre-certification and Pre-Service/Concurrent Care ***Claims***	**Monday through Friday 7 AM to 7 PM Central Time** **Customer Service 855.451.8365** **Magellan 800.424.0472** **Aetna 855.451.8365**
Website	**Gravie member website:** https://member.gravie.com **Aetna provider network directory:** www.aetna.com/asa **Magellan formulary list:** https://magellan.adaptiverx.com/webSearch/index?key=cnhmbGV4LnBsYW4uUGxhblBkZlR5cGUtNjU
Mailing Address	***Claims*, appeal requests, pre-certification, and written inquiries should be mailed to:** **Customer Service Department** **Gravie Administrative Services** **P.O. Box 211543** **Eagan, MN 55121**
Prescription Drugs **Magellan Rx**	**Telephone: 800.424.0472** **Website: www.magellanrx.com**

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I. Rights of *Covered Persons*

The *Plan*, as defined in Section II. *Your* Employer *(Plan Administrator)*, includes one or more health *benefit* options, which may have different eligibility requirements and/or *benefits*. If a different *Summary Plan Description (SPD), SPD* option, provision or amendment applies to certain *benefit* options or classifications of individuals eligible under the *Plan*, *you* will be furnished a copy of the *SPD, SPD* option, provision or amendment that is applicable to *you*. This *SPD* applies only to the Gravie Comfort $4,000 OOPM Medical Option and the eligible employees enrolled for participation in this option of the *Plan*.

As a participant in the *Plan*, *you* have certain rights and protections under the Employee Retirement Income Security Act of 1974 (*ERISA*), as amended.

ERISA provides that all *Plan* participants shall be entitled to:

Receive Information about this *Plan* and Its *Benefits*

- Examine, without charge, at the *Plan Administrator's* office and at other specified locations, such as work sites, all documents governing the *Plan*, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the *Plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the *Plan Administrator*, copies of documents governing the operation of the *Plan*, including insurance contract and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The *Plan Administrator* may make a reasonable charge for the copies.
- Receive a summary of the *Plan* annual financial report. The *Plan Administrator* is required by law to furnish *you* with a copy of the summary.

Continue Group Health Plan Coverage

- Continue health care coverage for *yourself* and/or *covered dependents* if there is a loss of coverage under the *Plan* as a result of a qualifying event. *You* may have to pay for such coverage. Review this *Summary Plan Description* and the documents governing the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating *your* rights, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. "Fiduciaries" of the *Plan* are the people who operate *your Plan* and have a duty to do so prudently, in *your* interest, in the interest of other *Plan* participants and *your* beneficiaries. No one, including *your* Employer or any other person, may fire *you* or otherwise discriminate against *you* in any way to prevent *you* from obtaining a *benefit* or exercising *your* rights under *ERISA*.

Enforce *Your* Rights

If *your claim* for *benefits* under the *Plan* is denied or ignored, in whole or in part, within certain time schedules *you* have a right to:

- Know why this was done;
- Obtain copies of documents relating to this decision without charge; and
- Appeal any denial.

Under *ERISA*, there are steps *you* can take to enforce the above rights. For instance, if *you* request a copy of *Plan* documents or the latest annual report from the *Plan* and do not receive them within 30 calendar days, *you* may file suit in a Federal court within two years of *your* request.

In such case, the court may require the *Plan Administrator* to provide the materials and pay *you* up to $110 a day until *you* receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If *you* have a *claim* for *benefits* under the *Plan* that is denied or ignored, in whole or in part, *you* may file suit in a state or Federal court, within two years of the *claim* denial, (if any), or if there is no *claim* denial within two years of the date of service. In addition, if *you* disagree with the *Plan Administrator's* decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, *you* may file suit in Federal court, within two years of the date of such order. If it should happen that *Plan* fiduciaries misuse the *Plan's* money, or if *you* are

discriminated against for asserting *your* rights, *you* may seek assistance from the U.S. Department of Labor, or *you* may file suit in Federal court, within two years of the date of such event. The court will decide who should pay court costs and legal fees. If *you* are successful, the court may order the person *you* have sued to pay costs and fees. If *you* lose, the court may order *you* to pay these costs and fees, for example, if it finds *your* claim frivolous.

Assistance with *Your* Questions

If *you* have any questions about *your Plan*, *you* should contact the *Plan Administrator*. If *you* have any questions about this statement or about *your* rights under *ERISA*, or if *you* need assistance in obtaining documents from the *Plan Administrator*, *you* should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in *your* telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C., 20210. *You* may also obtain certain publications about *your* rights and responsibilities under *ERISA* by calling the publications hotline of the Employee Benefits Security Administration (EBSA).

Your Rights and Responsibilities

You have the following rights and responsibilities:

1. A right to receive information about Gravie Administrative Services, its services, its *participating providers* and *your member* rights and responsibilities.
2. A right to be treated with respect and recognition of *your* dignity and right to privacy.
3. A right to available and accessible services, including *emergency services*, 24 hours a day, 7 days a week.
4. A right to be informed of *your* health problems and to receive information regarding treatment alternatives and risks that are sufficient to assure informed choice.
5. A right to participate with *providers* in making decisions about *your* health care.
6. A right to a candid discussion of appropriate or *medically necessary* treatment options for *your* conditions, regardless of cost or benefit coverage.
7. A right to refuse treatment.
8. A right to privacy of medical, dental, and financial records maintained by *your plan administrator* and its *participating providers* in accordance with existing law.
9. A right to voice complaints and/or appeals about *your plan administrator's* policies and procedures or care provided by *participating providers*.
10. A right to file a complaint with Gravie Administrative Services and the United States Department of Labor's Employee Benefits Security Administration and to initiate a legal proceeding when experiencing a problem with Gravie Administrative Services or its *participating providers*. For information, contact the United States Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) /www.dol.gov/ebsa/healthreform.
11. A right to make recommendations regarding member rights and responsibilities policies.
12. A responsibility to supply information (to the extent possible) that *participating providers* need in order to provide care.
13. A responsibility to supply information (to the extent possible) that *your plan administrator* requires for health plan processes such as enrollment, claims payment and benefit management, and providing access to care.
14. A responsibility to understand *your* health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
15. A responsibility to follow plans and instructions for care that *you* have agreed on with *your providers*.
16. A responsibility to advise *your plan administrator* of any discounts or financial arrangements between *you* and a *provider* or manufacturer for *health care services* that alter the charges *you* pay.

II. *Your* Employer (*Plan Administrator*)

Your Employer, which also serves as the *Plan Sponsor* and the *Plan Administrator*, has established an employee welfare benefit plan (the *Plan*) to provide health care *benefits*. This *Plan* is "self-insured" which means that the *Plan Sponsor* pays the claims from its own assets for *covered services*. The Gravie Comfort $4,000 OOPM Medical Option of this *Plan* is described in this *Summary Plan Description (SPD)*, which is part of the official document of the *Plan*. *Your* Employer has contracted with *Gravie* to provide claim processing, pre-certification, and other administrative services. However, *your* Employer is solely responsible for payment of *your* eligible claims.

The *Plan Administrator* in its sole discretion shall, to the fullest extent permitted by law, determine appropriate courses of action in light of the reason and purpose for which this *Plan* is established and maintained. The *Plan Administrator* has, to the fullest extent permitted by law, the exclusive and final discretionary authority to revise the method of accounting for the *Plan*, establish rules, and prescribe any forms required for administration of the *Plan*. All determinations and decisions made by or on behalf of the *Plan Administrator* will be final and binding on the *Plan*, all persons covered by the *Plan*, all persons or entities requesting payment or a *claim* for *benefits* under the *Plan* and all interested parties, to the fullest extent permitted by law. The *Plan Administrator* retains all fiduciary responsibilities with respect to the *Plan*, has the exclusive and final binding discretionary authority to interpret and administer the *Plan*, resolve any ambiguities that exist and make all factual determinations, to the fullest extent permitted by law, except to the extent the *Plan Administrator* has expressly delegated to other individuals or entities one or more fiduciary responsibilities with respect to the *Plan*.

The *Plan Sponsor*, by action of its governing body or an authorized officer or committee, reserves the right to change or terminate the *Plan*. This includes, but is not limited to, changes to *contributions, copayments, deductibles, coinsurance and out-of-pocket limits,* payable and any other terms or conditions of the *Plan*. The decision to change the *Plan* may be due to changes in federal laws governing welfare benefits, or for any other reason. The *Plan* may be changed to transfer the *Plan's* liabilities to another plan or split this *Plan* into two or more parts.

The *Plan Administrator* has the power to delegate specific duties and responsibilities. Any reference in the *SPD* to the *Plan Administrator* is also a reference to its delegated designee. Any delegation by the *Plan Administrator* may allow further delegations by such individuals or entities to whom the delegation has been made. The *Plan Administrator* may rescind any delegation at any time. Each person or entity to whom a duty or responsibility has been delegated, shall be responsible for only those duties or responsibilities and shall not be responsible for any act or failure to act of any other individual or entity.

III. Gravie Administrative Services (*Gravie, TPA*)

Gravie, as an external administrator referred to as a *third party administrator (TPA)*, provides certain administrative services, including claim processing services, subrogation, utilization management, and complaint resolution assistance.

IV. Introduction to *Your* Coverage

A. *Summary Plan Description (SPD)*

This *Summary Plan Description (SPD)* is *your* description of the Gravie Comfort $4,000 OOPM Medical Option of the *Plan Sponsor's Plan*. **Please read this entire *SPD* carefully. Many of its provisions are interrelated; so reading just one or two provisions may give *you* incomplete information regarding *your* rights and responsibilities under the *Plan***. The *SPD* describes the *Plan's benefits* and limitations for *your* health care coverage. Included in this *SPD* is a *Benefit* Schedule that states the amount payable for the *covered services*. *Benefits* are not covered for excluded services and exclusions include, but are not limited to, *health care services* that are not *medically necessary* as determined by the *Plan Administrator*. Be sure to review the list of exclusions as well as the *Benefit* Schedule. A *provider* recommendation or performance of a service, even if it is the only service available for *your* particular condition, does not mean it is a *covered service*. *Benefits* are not available for *medically necessary* services, unless such services are also *covered services*. ***Benefits* are limited to the most cost effective and *medically necessary* alternative**. The *Plan Administrator* has, to the fullest extent permitted by law, the sole, final, and exclusive discretion to determine *benefits* available under the *Plan*.

Italicized words used in this *SPD* have special meanings and are defined at the back of this *SPD*. *You* should keep *your SPD* in a safe place for *your* future reference. Amendments that are included with this *SPD* or adopted by the *Plan Sponsor* are fully made a part of this *SPD*.

This *SPD* is intended to comply with the Employee Retirement Income Security Act of 1974 (*ERISA*), as amended. This *Plan* is maintained exclusively for *you*. *Your* rights under the *Plan* are legally enforceable.

B. Administrative Services Agreement

The signed Administrative Service Agreement between *your* Employer and the *TPA* constitutes the entire agreement between *your* Employer and the *TPA*. A version of the Administrative Service Agreement is available for inspection from *your* Employer.

C. Identification Cards

The *TPA* issues an identification (ID) card containing important coverage information. Please verify the information on the ID card and notify Customer Service if there are errors. If any ID card information is incorrect, *claims* for *benefits* under the *Plan* or bills and/or invoices for *your* health care may be delayed or temporarily denied. *You* will be asked to present *your* ID card whenever *you* receive services.

D. *Provider* Directory

You may find *participating providers* on the designated website listed on the inside cover of this *SPD*. Coverage may vary according to *your provider* selection.

The list of *participating providers* frequently changes and the *TPA* does not guarantee that a listed *provider* is a *participating provider*. *You* may want to verify that the *provider you* choose is a *participating provider* by calling Customer Service at the telephone number listed on the inside cover of this *SPD*. If you call Customer Service, the *TPA* will respond to *you* as soon as practicable but in no case later than 1 business day after *your* call is received, through a written electronic communication or, at *your* request, a hard copy communication. *Provider* directories are available to *you* upon request.

If *You* called Customer Service, or used an Internet-based provider directory made available by the *TPA* to confirm that a *provider* was a *participating provider* before you received certain *health care services* from the *provider, but* the *provider* which furnished the *health care services* after *you* received such information was a *non-participating provider*:

Then the *Plan*:

(A) Shall not impose on *you* a cost-sharing amount (e.g. a *deductible* or *copayment*) for such *health care services* furnished by the *non-participating provider* that is greater than the cost-sharing amount that would apply had such *health care services* been furnished by a *participating provider*; and

(B) Shall apply the out-of-pocket maximum that would apply if such *health care services* were furnished by a *participating provider*.

E. For Non-*Emergency Services* Received in a *Participating Provider* Facility from a *Non-Participating Provider*

If a *participating provider* arranges and/or performs *health care services* for *you* at a *participating provider* facility, all related eligible non-facility charges from both *participating providers* and *non-participating providers*, will be covered at the *participating provider* level of *benefits* as shown in the "*Benefit* Schedule."

If a *non-participating provider* arranges or performs *health care services* for *you* at a *participating provider* facility, all related eligible non-facility charges from any *non-participating providers* will be covered at the *non-participating provider* level of *benefits* as described in the "*Benefit* Schedule." *You* will be responsible for any charges that may exceed the *usual and customary amount.*

F. Case Management/Alternative Care

In cases where *your* condition is expected to be or is of a serious nature, the *Plan Administrator* may arrange for review and/or case management services from a professional who understands both medical procedures and health care coverage under the *Plan*.

Under certain conditions, the *Plan Administrator* will consider other care, services, supplies, reimbursement of expenses, or payments of *your* serious *sickness* or *injury* that would not normally be covered or would only be partially covered. The *Plan Administrator* and *your physician* will determine whether any medical care, treatments, services, supplies, reimbursement of expenses or payments will be covered. Such care, treatment, services, supplies, reimbursable expenses, or payments provided will not be considered as setting any precedent or creating any future liability, with respect to *you*, or any other *covered person*.

Other care, treatments, services, or supplies must meet both of the following tests:

1. Be determined in advance by the *Plan Administrator* to be *medically necessary* and cost effective in meeting *your* long term or intensive care needs in connection with a catastrophic *sickness* or *injury*; and
2. The charges *incurred* would not otherwise be payable or would be payable at a lesser percentage.

Alternative Care

If *your attending health care professional* advises *you* to consider alternative care for a *sickness* or *injury* that includes *health care services* not covered under the *contract*, *your attending health care professional* should contact the Utilization Management Vendor who will contact the *Plan Administrator*. The *Plan Administrator* has full discretionary authority to consider paying for such non-covered *health care services* and may consider an alternative care plan if the *Plan Administrator* finds that:

1. The recommended alternative care offers a medical therapeutic value equal to or greater than the current treatment or confinement;
2. The current treatment or confinement is covered under this *SPD*;
3. The current treatment or confinement may be changed without jeopardizing *your* health; and
4. The *health care services* provided under the alternative care plan will be as cost effective as the *health care services* provided under the current treatment or confinement plan.

The *Plan Administrator* will make each alternative care coverage determination on a case by case basis and no decision will set any precedent for future claims. Payment of benefits, if any, will be determined by the *Plan Administrator.*

Any alternative care decision must be approved by *you*, the *attending health care professional*, and the *Plan Administrator* before such alternative care begins.

G. Conflict with Existing Law

If any provision of this *SPD* conflicts with any applicable law, only that provision is hereby amended to conform to the minimum requirements of the law.

H. Privacy

This *Plan* is subject to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule. In accordance with the HIPAA Privacy Rules, the *Plan* and the *TPA* acting on the *Plan's* behalf, maintains, uses, or discloses *your* Protected Health Information for purposes such as claims processing, utilization review, quality assessment, case management and otherwise as necessary to administer the *Plan*. *You* can obtain a copy of the *Plan's* Notice of Privacy Practices (which summarizes the *Plan's* HIPAA Privacy Rule obligations, *your* HIPAA Privacy Rule rights and how the *Plan* may use or disclose health information protected by the HIPAA Privacy Rule) from the *Plan Administrator*.

I. Processing Delays, Fraud, Misrepresentation, Rescission and Right to Audit

If routine processing delays occur, those delays will not deprive *you* of coverage for which *you* are otherwise eligible, nor will they give *you* coverage under the *Plan* for which *you* are not eligible under the *Plan*. *You* will not be eligible for coverage beyond the scheduled termination of *your* coverage because of a failure to record or communicate the termination except where required by law. It is *your* responsibility to confirm the accuracy of statements made by the *Plan Administrator* or the *TPA*, in accordance with the terms of this *SPD* and other plan documents. *Your* coverage may not be retroactively terminated unless *you* request it or *you* (or someone acting on *your* behalf) falsifies information, submits fraudulent, altered, or duplicate billings, allows another person not covered under the *Plan* to use *your* coverage, or performs an act or practice that constitutes fraud or intentional misrepresentation (including an omission) of material fact under the terms of the *Plan*. Notwithstanding, *you* may be terminated, including being retroactively terminated, due to *your* failure to timely pay *your* required *contributions*.

For the purpose of managing *your* overall health status, health conditions and diseases; for care coordination and quality improvement purposes; for disease management purposes; for claim processing purposes; and for payment purposes, by enrolling in coverage *you* authorize: (1) the *Plan* to disclose *your* health information with health care *providers* and subcontractors of health care *providers* or of the *Plan* that provide services; and (2) such health care *providers* and subcontractors to disclose *your* health information to each other and to the *Plan*.

Determination of *your* coverage will be made at the time a *claim* is reviewed. In addition, the *Plan Administrator* may require *you* to furnish proof of *your* eligibility status and may, at reasonable times and upon reasonable notice, audit or have audited *your* records regarding eligibility, enrollment, termination, *contributions,* and the coverage provided under the *Plan*. If the *Plan Administrator* determines that, after reasonable requests, *you* have failed to provide adequate records or sufficient proof of *your* eligibility status, the *Plan Administrator* may, in its sole discretion, rescind or terminate *your* coverage to the extent permitted by law.

J. Limited Access to *Participating Providers*

In the event that the *Plan Administrator* determines *you* are receiving *health care services*, including *prescription drugs*, in a quantity or manner that might be harmful to *your* health, the *Plan Administrator* will notify *you* that *your* access to *participating providers* is limited. *You* will have 30 calendar days in which to select one participating *physician, hospital,* and pharmacy to coordinate *your* health care. If *you* do not select those *participating providers* within 30 calendar days, the *Plan Administrator* will choose for *you.*

Failure to receive *health care services* through *your* selected *participating providers* will result in denial of coverage. If *your* condition requires care or treatment from other *providers*, *you* must obtain a written referral from *your* selected participating *physician*.

K. Summary of Benefits and Coverage (SBC)

The SBC is an informational summary of *your benefits* and coverage under this *SPD,* including coverage examples, that is prepared in a uniform style. If there is a conflict between this *SPD* and the SBC, this *SPD* governs and the *TPA* will administer your coverage in accordance with this *SPD*.

L. Medical Equipment, Supplies and *Prescription Drugs*

Your coverage under this *SPD* may provide different coverage options for medical equipment, supplies or *prescription drugs* than your coverage under a previous *calendar year*.

M. *Routine Patient Costs* Associated with *Clinical Trials*

The *Plan* covers *routine patient costs* associated with a *clinical trial* and may not: 1) deny *your* participation in a *clinical trial*; 2) deny (or limit or impose additional conditions on) the coverage of *routine patient costs* for items and *health care services* furnished to *you* in connection with participation in the *clinical trial*; or 3) discriminate against *you* on the basis of *your* participation in a *clinical trial.*

If one or more *participating providers* are participating in a *clinical trial*, the *Plan* will cover *routine patient costs* only if *you* participate in the *clinical trial* through a *participating provider* if the *provider* will accept *you* in the *clinical trial.* This requirement is waived if the approved *clinical trial* is conducted outside the state in which *you* reside. However, the *Plan* will not cover *routine patient costs* if *you* are in a *clinical trial* with a *non-participating provider* and *you* do not have coverage for *non-participating provider benefits*.

N. Essential Health Benefits Benchmark

Employer acknowledges and agrees that, to the extent required by the *Affordable Care Act*, the *essential health benefits* of the Utah benchmark apply to the *Plan*.

O. Balance Billing

(1) If you receive *emergency services* (for which benefits are provided under this *SPD*) because of an *emergency medical condition* with respect to a visit at an *emergency department of a hospital* or an *independent freestanding emergency department*, which is a *non-participating provider,* then such *non-participating provider* may not bill *you*, and may not hold *you* liable, for any amount for such *emergency services* which is more than the *copayment* requirement for such services by *participating provider*s under this *SPD*.

(2) If a *non-participating provider* furnishes *health care services* other than *emergency services* (for which benefits are provided under this *SPD*) to *you* at a *hospital* or ambulatory surgical center, which is a *participating provider*, then:

a) The *non-participating provider* may not bill *you*, and may not hold *you* liable, for any amount for such *health care services* furnished by such *non-participating provider* with respect to a visit at the *hospital* or ambulatory surgical center which is more than the *deductible* requirements for such services under this *SPD*; unless;

b) The *health care services* are not *ancillary services* and the *non-participating provider* satisfies the notice and consent criteria in paragraph (c).

c) The *non-participating provider* provides to the *covered person*:

i. A written notice in paper or electronic form, as selected by *you*, that contains the following information:

- A statement that the *provider* is a *non-participating provider*;
- The good faith estimated amount that such *non-participating provider* may charge *you* for the *health care services* involved (and any other related *health care services* reasonably expected to be furnished by the *non-participating provider*), including notification that the provision of the estimate or consent does not constitute a contract with respect to the estimated charges or a contract that binds the *covered person* to be treated by the *hospital*, ambulatory surgical center, or *non-participating provider*;
- A statement that prior notification or other care management limitations may be required in advance of receiving such *health care services* at the *hospital* or ambulatory surgical center;
- A statement that consent to receive such *health care services* from such *non-participating provider* is optional and that the *covered person* may instead seek care from an available *participating provider* and in that event the cost-sharing responsibility of the *covered person* would not exceed the responsibility that would apply with respect to such *health care services* furnished by a *participating provider*.

ii. A consent form that must be signed by the *covered persons* before such *health care services* are furnished and that:

- Acknowledges that the *covered person* has been:
  - Provided with the written notice described in paragraph (i) of this subsection, in the form selected by the *covered person*; and

- Informed that the payment of such charge by the *covered person* might not accrue toward meeting any limitation that *your* coverage places on cost sharing, including an explanation that such payment might not apply to an in-network *deductible* or *out-of-pocket maximum* applied under *your* coverage;

- States that by signing the consent form, the *covered person* agrees to be treated by the *non-participating provider* and understands the *covered person* may be balance billed and subject to cost sharing requirements that apply to *health care services* furnished by the *non-participating provider*; and

- Documents the time and date on which the *covered person* received the written notice described in paragraph (i) of this subsection and the time and date on which the *covered person* signed the consent form to be furnished such *health care services* by such *non-participating provider*.

The No Surprises Act prohibits balance billing in most circumstances. If you have questions regarding what constitutes a "Balance" bill, please contact Customer Service at the number listed on the inside cover of this *SPD*.

P. Continuity of Care

1) If you are a *continuing care patient* and:

   a) The *Plan Administrator's* contract with the *participating provider* that is providing *your* continuing care terminates for any reason other than the *participating provider*'s failure to meet applicable quality standards or fraud;

   b) *Your* benefits under this *SPD* for the *health care services* provided by the *participating provider* that is providing *your* continuing care terminate because of a change in the terms of the *Plan Administrator* contract with such *participating provider*.

2) Then:

   a) The *Plan Administrator* will notify *you* of the applicable event described in (1) and *your* right to elect continued transitional care from such *non-participating provider* (in the event of notice under (1)(A)) or such *participating provider* (in the event of notice under (1)(B));

   b) The *Plan Administrator* will provide *you* with an opportunity to notify the *Plan* of *your* need for transitional care; and

   c) The *Plan Administrator* will allow *you* to elect to continue to have benefits for transitional care provided under this *SPD*, under the same terms and conditions as would have applied under this *SPD* had the applicable termination not occurred, as long as such benefits are for the course of treatment provided by such *non-participating provider* (in the event of notice under (1)(A)) or such *participating provider* (in the event of notice under (1)(B)) relating to *your* status as a *continuing care patient* during the period beginning on the date on which the notice in (2)(A) is provided and ending on the earlier of:

      i. The 90-day period beginning on such date; or

      ii. The date on which *you* are no longer a *continuing care patient* of such *non-participating provider* (in the event of notice under (1)(A)) or such *participating provider* (in the event of notice under (1)(B)).

Q. Transition of Care

If a *covered person* is under the care of a *non-participating provider* at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a *non-participating provider* may be covered at the *participating provider* level of benefits for a limited period of time. The *TPA* will review and approve or deny such requests.

R. Binding Arbitration

NOTE: The Employee is enrolled in a plan provided by the Employer that is subject to ERISA. Any dispute involving an Adverse Benefit Determination must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. The individual may pursue voluntary binding arbitration after he or she has completed an appeal under ERISA. If the individual has any other dispute which does not involve an Adverse Benefit Determination, this Binding Arbitration provision applies.

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

S. Clerical Error/Delay

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 to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by *covered persons* due to such clerical error will be returned to the *covered person*; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the *Plan*, as if no clerical error had occurred. 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 incorrect amount of money. In the case of a *covered person*, the amount of overpayment may be deducted from future benefits payable.

T. Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the TPA for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be retained by this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a covered person subsequently requests payment with respect to the voided check, the Plan Sponsor for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed.

V. Eligibility, Enrollment, and *Effective Date*

A. Eligibility

You are eligible to enroll for coverage if *you* are:

1. Classified by the *Plan Sponsor* as a full-time employee whose standard hours are a minimum of 30 hours per week.

2. An eligible dependent of the employee. An employee must enroll for coverage in order to enroll eligible dependents. If both parents are covered as employees, a child may be covered as a dependent of either parent, but not both.

Eligible dependents include a *covered employee's*:

1. Lawful spouse whose marriage to the *covered employee* is valid under applicable state law.

2. Children, from birth through end of the month in which the child reaches age 26, including:
   a. Natural child;
   b. Child who is legally adopted by or placed with *covered employee* for legal adoption from the earlier of the adoption date or the date of placement for adoption. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support;
   c. Stepchild;
   d. Child for whom *covered employee* is designated a foster parent by an authorized social services agency or by a court of law;
   e. Child for whom *covered employee* is the legal guardian appointed by a court of law;
   f. Child covered under a valid Qualified Medical Child Support Order (QMCSO), as defined under section 609 of the Employee Retirement Income Security Act (*ERISA*) and its implementing regulations, which is enforceable against an eligible employee or a *covered employee*. An eligible employee or a *covered employee* may contact the *Plan Administrator* for free assistance in obtaining information regarding the procedures governing QMCSO determinations. The *Plan Administrator* is responsible for determining whether or not a medical child support order is a valid QMCSO.

3. Same-sex or Opposite-sex domestic partner solely for the purpose of eligibility for coverage under this *SPD*, but excluding eligibility for COBRA Continuation Coverage, if *covered employee* and the domestic partner meet all of the following:
   a. Share the same legal residence;
   b. Are jointly responsible for basic living expenses;
   c. Are not married to anyone, are each other's sole domestic partner and intend to remain together for a long-lasting and indefinite period;
   d. Are each 18 years of age or older;
   e. Are not related by blood closer than permitted under the marriage laws of the state of residence;
   f. Are each mentally competent to consent to a contract; and
   g. Have completed a domestic partnership affidavit form and have agreed to the conditions of such form.

   Children of *covered employee's* covered domestic partner are eligible for coverage as eligible dependents through end of the month in which the child reaches age 26.

4. Dependent children who are disabled. Application for extended coverage and proof of incapacity must be furnished to the *Plan Administrator* within 31 calendar days after the dependent child reaches age 26. The *Plan Administrator* may ask for an independent medical exam to determine the functional capacity of the dependent child. After this initial proof, the *Plan Administrator* may request proof again as needed. A dependent child may be eligible for coverage if coverage has not otherwise terminated under this *Plan* and if the dependent child meets all of the following criteria:
   a. Became disabled before age 26;
   b. Was a *covered dependent* under the *Plan* prior to reaching age 26;
   c. Is incapable of self-sustaining employment, because of a *physical disability*, developmental mental disability, mental illness, or mental health disorder that is expected to be ongoing for a continuous period of at least two years from the date initial proof is supplied to the *Plan*;
   d. Is dependent on *covered employee* for a majority of financial support and maintenance; and

e. Is unmarried.

If the dependent child is disabled and 26 years of age or older at the time of the *covered employee's* enrollment in this *Plan*, the *covered employee* may enroll the dependent child if within 31 calendar days after the *covered employee's* initial enrollment in this *Plan* the *covered employee* provides the *Plan* with proof that such dependent child meets all of the following requirements:

a. Became disabled before age 26;
b. Received health coverage through the *covered employee* within the 60-day period immediately preceding the *covered employee's* enrollment for coverage under this *Plan*;
c. Is incapable of self-sustaining employment, because of a *physical disability*, developmental mental disability, mental illness, or mental health disorder that is expected to be ongoing for a continuous period of at least two years from the date initial proof is supplied to the *Plan*;
d. Is dependent on *covered employee* for a majority of financial support and maintenance; and
e. Is unmarried.

The *Plan Administrator* may also request an independent medical examination to determine the functional capacity of the dependent child. The disabled dependent child shall be eligible for coverage provided that the *covered employee* provides the *Plan Administrator* with ongoing proof, as requested by the *Plan Administrator,* that such dependent child is and continues to be disabled and dependent on the *covered employee*, as described above, unless coverage otherwise terminates under this *SPD*.

B. Enrollment and *Effective Date*

New Enrollment. The eligible employee must apply to enroll, including any eligible dependents that the eligible employee wishes to enroll, and pay any required *contribution*, within 31 calendar days of the date the employee first becomes eligible. Coverage will be effective on the first day of the month following a 60 day waiting period..

Annual Enrollment. Subject to all eligibility and enrollment provisions, the employee may enroll, and may include eligible dependents; or a *covered employee* may add eligible dependents during the Employer's annual enrollment period. Coverage will be effective on the date indicated during the annual enrollment.

Special Enrollment Period for Employees and Dependents. If *you* are an eligible employee or an eligible dependent of an eligible employee but not enrolled for coverage under this *Plan*, *you* may enroll for coverage under the terms of this *Plan* if all the following conditions are met:

1. *You* were covered under a group health plan, covered under the MinnesotaCare program as defined in Minnesota Statutes Chapter 256L or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The eligible employee stated in writing at the time of initial eligibility that coverage under a group health plan, the MinnesotaCare program as defined in Minnesota Statutes Chapter 256L, or health insurance coverage was the reason for declining enrollment, but only if the Employer required a statement at such time and provided the employee with notice of the requirement and the consequences of such requirement at the time;

3. *Your* coverage described in paragraph 1 above was:
   a. Terminated under a COBRA or state continuation provision and the coverage under such provision was exhausted; or
   b. Terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer *contributions* toward such coverage were terminated; or
   c. Terminated as a result of loss of eligibility for the MinnesotaCare program as defined in Minnesota Statutes Chapter 256L; or
   d. Coverage under a group health plan with a plan year that differs from the plan year applicable to coverage under this *SPD* and such coverage ended either at the close of such other group health plan's plan year in relation to an open enrollment period or upon the occurrence of one or more of the following qualifying change in status events experienced by the eligible employee or dependent, but only to the extent such event is recognized under this Employer's Section 125 cafeteria plan, if applicable:

      i. A significant reduction in benefits available under the other group health plan; or
      ii. A significant increase in the cost charged to the eligible employee or dependent for coverage under the other group health plan; or

iii. A reduction in working hours that caused a significant increase in the cost charged to the eligible employee or dependent for coverage under the other group health plan; or

iv. A covered dependent is eligible to enroll in an individual health insurance plan through the Marketplace. An employee is allowed to drop group health plan coverage and reduce their pre-tax election amount for group medical premiums mid-year from family to self-only coverage if the following conditions are met:

1. One or more of the employee's dependents are eligible for a special or open enrollment period in the Marketplace, and

2. The change to the employee's election is related to their dependent(s) intended enrollment in individual health insurance coverage through the Marketplace. The Marketplace health insurance coverage must be effective beginning no later than the day immediately following the last day they are covered under the employee's employer plan; and

4. The eligible employee requested such enrollment not later than 31 calendar days after the date of the event described in paragraphs 3.a, 3.b or 3.d above, or not later than 60 calendar days after the date of loss of eligibility for the MinnesotaCare program as defined in Minnesota Statutes Chapter 256L described in paragraph 3.c above.

Coverage will be effective on the date of the event described in paragraphs 3.a - c above or on the date action is taken under the other group health plan's contract for the events described in paragraph 3.d above, provided the *Plan* receives the application for coverage as required.

Special Enrollment Period for *Covered Persons* due to the Acquisition of New Dependents. New dependents may enroll if all the following conditions are met:

1. A group health plan makes coverage available to a dependent of an employee; and

2. The employee is eligible for coverage under this *Plan*; and

3. They become dependents of the employee through marriage, birth, adoption, placement for adoption, or legal guardianship. This *Plan* shall provide a dependent special enrollment period during which the person may be enrolled under this *Plan* as a dependent of the employee, and in the case of the birth, adoption, children placed for adoption, or the legal guardianship of a child, the employee may enroll and the spouse of the employee may be enrolled as a dependent of the employee if such spouse is otherwise eligible for coverage. The eligible employee, if not previously enrolled, is required to enroll when a dependent enrolls for coverage under this *Plan*. In the case of marriage, the employee, the spouse, and any new dependents resulting from the marriage may be enrolled, if otherwise eligible for coverage; and

4. Application must be received within 31 calendar days of the date the employee first acquires the dependent and coverage will be effective on the date of the marriage, birth, adoption, placement for adoption, or legal guardianship as described in paragraph 3 above.

Notwithstanding paragraph 4 above, if a *covered employee* has a spouse and/or dependent child/children covered under this *Plan* and subsequently acquires an eligible dependent child through birth or adoption, the newly acquired dependent child will be considered covered under the *Plan* effective on the date of the birth or adoption, provided that the employee enrolls the newly acquired dependent child within 60 days of the birth or adoption.

Note: Other dependents (such as siblings of a newborn child) are entitled to special enrollment rights upon the birth or adoption of a child.

Special Enrollment Period for Medicaid and Children's Health Insurance Program (CHIP) Participants. If an eligible employee and/or the eligible employee's eligible dependents are covered under a state Medicaid Plan or a state CHIP (if applicable) and that coverage is terminated as a result of loss of eligibility, then such employee may request enrollment in the *Plan* on behalf of the eligible employee and/or eligible dependents. Such request shall be submitted to the *Plan* not later than 60 calendar days after the eligible employee's and/or the eligible employee's dependent's coverage ends under such state plans.

If an eligible employee and/or the eligible employee's eligible dependents become eligible for coverage under a state Medicaid Plan or a state CHIP (if applicable), and the Employer has not opted out of the premium assistance subsidy offered by the state, then such employee may request enrollment in the *Plan* on behalf of the eligible employee and/or such eligible dependents. The eligible employee shall request such enrollment in the *Plan* no later than 60 calendar days after the date the employee and/or the eligible employee's eligible dependents are determined to be eligible for coverage under such state plans.

VI. *Benefit* Schedule

You are required to pay any *copayment*, *deductible*, *coinsurance,* and *out-of-pocket limit. Benefits* listed in this Schedule are according to what the *Plan* pays. *Benefits* are limited to the most cost effective and *medically necessary* alternative. Any amount of *coinsurance you* must pay to the *provider* is based on 100% of *eligible charges* less the percentage covered by the *Plan*. *Plan* payment begins after *you* have satisfied any applicable *copayments*, *deductibles*, *coinsurance* and/or *out-of-pocket limit.*

Discounts negotiated by or on behalf of the *TPA* with *providers* may affect *your* cost sharing amount. This *Plan* may pay higher *benefits* if *you* choose a *participating provider*. If *you* use a *non-participating provider*, in addition to any *copayments*, *deductibles, coinsurance*, *you* pay all charges that exceed the *usual and customary amount,* when applicable.

A. Pre-certification Requirement and Prior Notification Recommendation

Pre-certification or prior notification of *health care services* does not guarantee either payment or the amount of payment. Eligibility for, and payment of, *benefits* are subject to all terms of the *SPD*. Please read the entire *SPD* to determine which other provisions may also affect *benefits*. The Utilization Management vendor only certifies that the *health care services* are *medically necessary*.

Pre-certification Requirement: Pre-certification requires that *you* or *your provider* request that certain *health care services* be authorized as *medically necessary* in advance by your plan's Utilization Management vendor.

Pre-certification by the Utilization Management vendor is required for the following *health care services:*

- All non-*emergency* inpatient admissions including but not limited to *hospital*, *skilled nursing facility*, rehabilitation; and
- *Transplant services*.

Pre-certification penalties do not apply; however, your *plan* does require submission for authorization to be completed for all services requiring pre-certification.

If *you* have questions about pre-certification and when *you* are required to obtain it, please contact *Gravie* for assistance.

Prior Notification Recommendation: Prior Notification is a screening process that permits early identification of situations where case management would be beneficial, or medical management is required. Prior Notification can be made by *you* or *your provider* calling the Utilization Management vendor during normal business hours and before certain services are performed. This telephone number for the Utilization Management vendor is shown on the inside cover of this *SPD*.

Prior notification is recommended before the following medical services are received. Prior notification penalties do not apply:

- *Emergency* Inpatient Admissions;
- Drugs or procedures that could be construed to be *cosmetic*;
- Durable medical equipment (DME) and prosthesis that may exceed $5,000;
- Home health care;
- Hospice services;
- Non-*emergency* transportation;
- Outpatient surgeries;
- The following outpatient diagnostic services:
  - PET
  - Capsule endoscopy
  - Genetic Testing (including BRCA)
  - Sleep Study
  - CT for non-orthopedic
  - MRI for non-orthopedic
- The following outpatient continuing care services:
  - Chemotherapy (including oral)
  - Radiation Therapy
  - Oncology and transplant related injections, infusions and treatments (e.g. CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g. antiemetic and antihistamine)

- Hyperbaric Oxygen
- Dialysis; and

- Pain therapy programs.

Certain *prescription drugs* may require prior authorization before *you* can have *your* prescription filled at the pharmacy. For information, you may call Magellan Rx at the phone number listed on the inside front cover of this *SPD.* These *prescription drugs* may include, but are not limited to:

- *Prescription drugs* over:
  a. $300 if a *compounded drug*;
  b. $1,500 if a retail prescription; or
- *Specialty drugs.*
- *Prescription drugs* for the treatment of *infertility*.

Should Minnesota and/or the Minneapolis/St. Paul metropolitan area be declared subject to a pandemic alert or in the event of a cyber-attack, the *Plan* may suspend pre-certification requirements, prior notification requirements and other services as may be determined by the *Plan Administrator*.

Pre-Certification Procedure for Non-Acute Care Pre-Service *Claims*

Non-acute care pre-service *claims* are *claims* for non-acute care services that require pre-certification and are submitted in accordance with the pre-service *claim* filing procedures for the *Plan*.

Filing Procedure for Non-Acute Care Pre-Service *Claims*. To request pre-certification and file a non-acute care pre-service *claim*, a phone call must be made to the Utilization Management vendor at the telephone number shown on your id card and on the inside cover of this SPD at least seven business days before the date services requiring pre-certification are provided and all essential data elements must be supplied. An expedited review is available if *your* attending *provider* believes *your* medical condition warrants it. Please refer to the subsection below entitled "Essential Data Elements for Pre-Service *Claims*" for the list of essential data elements that are required to file a pre-service *claim*. If *you* or *your* attending *provider* have not submitted the request in accordance with these filing procedures, including a failure to submit all essential data elements, *your* request will be treated as incorrectly filed, and *you* will be notified within five calendar days. Please note that the time periods for making an initial *benefit* determination begin when the Utilization Management vendor receives a pre-certification request submitted in accordance with the *Plan's* filing procedures.

If *your* attending *provider* requests pre-certification on *your* behalf, the *provider* will be treated as *your* authorized representative under the *Plan* for purposes of such request and the submission of *your claim* and associated appeals unless *you* provide the *TPA* with specific direction otherwise within three business days from the *Plan Administrator's* notification that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

A request or inquiry relating to the availability of *benefits* or payment for future services that do not require pre-certification will not be treated as a *claim* under the *Plan*.

Initial *Benefit* Determination of Non-Acute Care Pre-Service *Claims*. *You* and *your* attending *provider* will be notified of the *TPA's* initial *benefit* determination within 15 calendar days (or a shorter time period as required by applicable law) after receipt of a pre-certification request submitted in accordance with the *Plan's* filing procedures, provided the *TPA* has all necessary information needed to make an initial *benefit* determination.

If the *TPA* does not have all information it needs to make an initial *benefit* determination, or in other circumstances permitted by law, then it may extend the time period for making the initial *benefit* determination by 15 calendar days (or a shorter time period as required by applicable law). The *TPA* will notify *you* of the extension and the time period to provide the requested information. If *you* do not provide the requested information within the time period specified, *your claim* will be denied.

The initial *benefit* determination may be made to *your* attending *provider* by telephone.

If *your* pre-certification request is denied, written notification will be provided to *you* and *your* attending *provider*. This notice will explain:

- Information sufficient to identify the *claim* involved and any information required by law;
- The reason for the denial;
- The part of the *Plan* on which it is based;

- Any additional material or information needed to make the *claim* acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

Note: Refer to the section entitled "*Claim* Appeals Process" for details on requesting an appeal or external review.

Expedited Pre-Certification Procedure for Acute Care Pre-Service *Claims*

Acute care services are services needed when a delay in treatment could seriously jeopardize *your* life or health or the ability to regain maximum function or, in the opinion of *your* attending *provider*, could cause severe pain. An expedited initial *benefit* determination will be made for *claims* for services that require pre-certification and are submitted in accordance with the pre-service *claim* filing procedures for the *Plan*, if *your* attending *provider* believes *your* medical condition warrants acute care services.

Filing Procedure for Acute Care Pre-Service *Claims*. To request expedited pre-certification and file an acute care pre-service *claim*, a phone call must be made to the Utilization Management vendor before the date services requiring pre-certification are provided and all essential data elements must be supplied. Please refer to the subsection below entitled "Essential Data Elements for Pre-Service *Claims*" for the list of essential data elements that are required to file a pre-service *claim*. If *you* or *your* attending *provider* have not submitted the request in accordance with these filing procedures, including a failure to submit all essential data elements, *your* request will be treated as incorrectly filed, and *you* will be notified within 24 hours. Please note that the time periods for making an expedited initial *benefit* determination begin when the Utilization Management vendor receives a pre-certification request submitted in accordance with the *Plan's* filing procedures.

If *your* attending *provider* requests pre-certification on *your* behalf, the *provider* will be treated as *your* authorized representative under the *Plan* for purposes of such request and the submission of *your claim* and associated appeals unless *you* provide the *TPA* with specific direction otherwise within three business days from the *Plan Administrator's* notification that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

A request or inquiry relating to the availability of *benefits* or payment for future services that do not require pre-certification will not be treated as a *claim* under the *Plan*.

Expedited Initial *Benefit* Determination of Acute Care Pre-Service *Claims*. An expedited initial *benefit* determination will be provided by the *TPA* to *you* and *your* attending *provider* as quickly as *your* medical condition requires, but no later than 72 hours (or such shorter time as required by applicable law) following receipt of a pre-certification request submitted in accordance with the *Plan's* filing procedures.

If the *TPA* does not have all information it needs to make an initial *benefit* determination, *you* will be notified within 24 hours. *You* will then have 48 hours, or longer time as granted to *you* in the notification, to provide the requested information. If *you* do not provide the requested information within the time period specified, *your* request will be denied. *You* will be notified of the initial *benefit* determination within 48 hours after the earlier of the *TPA's* receipt of the requested information or the end of the time period specified for *you* to provide the requested information.

The initial *benefit* determination may be made to *your* attending *provider* by telephone.

If *your* pre-certification request is denied, written notification will be provided to *you* and *your* attending *provider*. This notice will explain:
- Information sufficient to identify the *claim* involved and any information required by law;
- The reason for the denial;
- The part of the *Plan* on which it is based;
- Any additional material or information needed to make the *claim* acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

Note: Refer to the section entitled "*Claim* Appeals Process" for details on requesting an appeal or external review.

Essential Data Elements for Pre-Service *Claims* (including Concurrent Care *Claims*)

You or *your* attending *provider* must submit at least the following essential data elements when calling the Utilization Management vendor to request pre-certification and file a pre-service *claim* (or requesting to extend a previously pre-certified treatment and file a concurrent care *claim*):
- The identity of the *covered person* and *provider* of services;

- The date(s) of services;
- A specific medical diagnosis; and
- A specific treatment, *health care service*, or procedure code for which pre-certification approval (or extended treatment) is requested.

An explanation of these essential data elements will be provided to *you*, upon request and free of charge, by calling the Utilization Management vendor. If *you* or *your* attending *provider* have not submitted the pre-certification (or extended treatment) request in accordance with the *Plan's* filing procedures for pre-service *claims*, including a failure to submit all essential data elements, *your* request will be treated as incorrectly filed and *you* will be notified within applicable timeframes.

Procedure for Concurrent Care *Claims*

Filing Procedure for Concurrent Care *Claims*. If an ongoing course of treatment was pre-certified by the *Plan Administrator* for a specified period of time or number of treatments and *you* or *your* attending *provider* request to extend acute care services, *your* extension request and concurrent care *claim* must be submitted in accordance with the filing procedure for acute care pre-service *claims*, as described above. If an ongoing course of treatment was pre-certified by the *Plan Administrator* for a specified period of time or number of treatments and *you* or *your* attending *provider* request to extend non-acute care services, *your* extension request and concurrent care *claim* must be submitted in accordance with the filing procedure for non-acute care pre-service *claims*, as described above. If *you* or *your* attending *provider* have not submitted the extension request in accordance with the *Plan's* filing procedures, including a failure to submit all essential data elements, *your* request will be treated as incorrectly filed and *you* will be notified within 24 hours in the case of a request to extend acute care services, and within five calendar days in the case of a request to extend non-acute care services. Please note that the time periods for making an initial *benefit* determination begin when the Utilization Management vendor receives an extended treatment request submitted in accordance with the *Plan's* filing procedures.

If *your* attending *provider* requests extended treatment on *your* behalf, the *provider* will be treated as *your* authorized representative under the *Plan* for purposes of such request and the submission of *your claim* and associated appeals unless *you* provide the *TPA* with specific direction otherwise within three business days from the *Plan Administrator's* notification that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

A request or inquiry relating to the availability of *benefits* or payment for future services or extended treatments that do not require pre-certification will not be treated as a *claim* under the *Plan*.

Initial *Benefit* Determination of Concurrent *Claims*. If an ongoing course of treatment was previously pre-certified for a specified period of time or number of treatments and *you* request to extend acute care services, the *TPA* will make the initial *benefit* determination on *your* extended treatment request within 24 hours following receipt of a properly filed extended treatment request, provided *your* request is made at least 24 hours before the end of the approved treatment. If a properly filed request for extended treatment is not made at least 24 hours before the end of the approved treatment, *your* request will be treated as a pre-certification request for acute care services and handled in accordance with the expedited pre-certification procedures outlined above for such services.

If an ongoing course of treatment was previously pre-certified for a specified period of time or number of treatments and *you* request to extend non-acute care services, *your* request will be treated as a pre-certification request for non-acute care services and handled in accordance with the pre-certification procedures outlined above for such services.

The initial *benefit* determination may be made to *your* attending *provider* by telephone.

If *your* concurrent care *claim* and extended treatment request is denied, written notification will be provided to *you* and *your* attending *provider*. This notice will explain:

- Information sufficient to identify the *claim* involved and any information required by law;
- The reason for the denial;
- The part of the *Plan* on which it is based;
- Any additional material or information needed to make the *claim* acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

Note: Refer to the section entitled "*Claim* Appeals Process" for details on requesting an appeal or external review.

B. *Deductible* and *Out-of-Pocket Limit*	**NOTE:** *Your* coverage is either "*covered employee* only" or "family." Therefore, only one of the following sections ("*Covered employee* only" or "Family") applies to *you*, unless the *Plan* expressly provides otherwise. If *you* have questions about which section applies to *you*, contact *TPA* or *your* employer.

***Covered Employee* Only**

Deductible: For this *Plan,* the *deductible* for *health care services* from *participating providers* is the same as the *out-of-pocket limit* for *health care services* from *participating providers.* Once *you* have *incurred eligible charges* equal to the *deductible* shown below, the *Plan* will pay *benefits* for the rest of the *calendar year. You* must submit copies of bills for *eligible charges* used to satisfy the *deductible* to the *TPA*. Expenses *you* pay for *copayments* and any amount in excess of the *usual and customary amount* will not apply to the *deductible*. Except as described below, a separate deductible applies for health care services from *non-participating providers*.

***Out-of-Pocket Limit*:** The *out-of-pocket limit* applies to *health care services* received from *participating providers.* Except as described below, if *you* receive services from a *non-participating provider,* the *out-of-pocket limit* does not apply. After the *covered employee* has met the *out-of-pocket limit* per *plan year* for *health care services* from *participating providers,* the *Plan* covers the remaining *eligible charges incurred* from *participating providers* for the remainder of the *calendar year.* It is the *covered employee's* responsibility to demonstrate to the *Plan* that the *out-of-pocket limit* is satisfied, and to pay any amounts greater than the *out-of-pocket limits* if any *benefit*, day, or visit maximums are exceeded. Expenses *you* pay for *copayments* will apply to the *out-of-pocket limit*.

Covered Employee Only	***Participating Providers (and certain Non-Participating Providers)***	***Other Non-Participating Providers***
Deductible	$4,000 per *covered person* per *plan year* for *eligible charges* from *participating providers*, charges calculated for ***non-participating providers*** of *emergency services*, charges calculated for ***non-participating providers*** of air ambulance services, and charges calculated for ***non-participating providers*** of non-*emergency services* at a *hospital* or ambulatory surgical center which is a *participating provider.**	$10,000 per *covered person* per *plan year* for *eligible charges* from *non-participating providers.*
Out-of-Pocket Limit	$4,000 per *covered person* per *plan year* for *eligible charges* from *participating providers*, charges calculated for ***non-participating providers*** of *emergency services*, charges calculated for ***non-participating providers*** of air ambulance services, and charges calculated for ***non-participating providers*** of non-*emergency services* at a *hospital* or ambulatory surgical center which is a *participating provider.**	None.

Family (*Covered Employee* and *Covered Dependents*)

Family *Deductible*: The family must satisfy the family *deductible* per *plan year* for *health care services* before the *Plan* will pay *benefits* for the family in that *calendar year.* There is an embedded *deductible* shown in the table below that applies for each *covered person* within the family. If any *covered person* within the family satisfies such embedded *deductible,* the *Plan* will pay *benefits* for such *covered person* before the family *deductible* is met. Copies of bills for *eligible charges* used to satisfy the *deductible* must be submitted to the *Plan*. The *Plan* will not pay *benefits* for the *eligible charges* applied toward the *deductible*. Expenses *you* pay for *copayments* and any amount in excess of the *usual and customary amount* will not apply to the *deductible*.

Family *Out-of-Pocket Limit*: The family *out-of-pocket limit* applies to *health care services* received from *participating providers.* There is an embedded *out-of-pocket* limit shown in the table below that applies for each *covered person* within the family. If any *covered person* within the family satisfies such embedded *out-of-pocket* limit, the *Plan* will pay *benefits* for such *covered person* before the family *out-of-pocket* limit is met. If *you* or *your covered dependents* receive services from a *non-participating provider,* the *out-of-pocket limit* does not apply. After the family has met the family *out-of-pocket limit* per *plan year* for *health care services* from *participating providers,* the *Plan* covers the remaining *eligible charges incurred* from *participating providers* for the remainder of the *calendar year.* It is the family's responsibility to demonstrate to the *Plan* the family *out-of-pocket limit* has been satisfied and to pay any amounts greater than the family *out-of-pocket limit* if any *benefit*, day, or visit maximums are exceeded. Expenses *you* pay for *copayments* will apply to the family *out-of-pocket limit*.

Family (*Covered Employee* and *Covered Dependents*)	***Participating Providers***	***Non-Participating Providers***
Family *Deductible*	$8,000 per family ($4,000 per *covered person)* per *plan year* for *eligible charges* from ***participating providers***, charges calculated for ***non-participating providers*** of *emergency services*, charges calculated for ***non-participating providers*** of air ambulance services, and charges calculated for ***non-participating providers*** of non-*emergency services* at a *hospital* or ambulatory surgical center which is a *participating provider*.*	$20,000 per family ($10,000 per *covered person*) per *plan year* for *eligible charges* from *non-participating providers.*
Family *Out-of-Pocket Limit*	$8,000 per family ($4,000 per *covered person*) per *plan year* for *eligible charges* from ***participating providers***, charges calculated for ***non-participating providers*** of *emergency services*, charges calculated for ***non-participating providers*** of air ambulance services, and charges calculated for ***non-participating providers*** of non-*emergency services* at a *hospital* or ambulatory surgical center which is a *participating provider*.*	None.

Cost Sharing. The amounts of the flat fee *copayments* vary as described later in this Section VI of the *SPD*. The calculation of the *coinsurance* is based on the least of the *provider's* allowed charge, the *fee schedule* negotiated by the *TPA* with the *participating provider*, or the *usual and customary amount*, except for: (1) the calculation of the *coinsurance* for *emergency services* provided by a *non-participating provider*, in which case, the calculation of the *coinsurance* will be based on the *recognized amount*; (2) the calculation of the *coinsurance* for air ambulance services provided by a *non-participating provider*, in which case, the calculation of the *coinsurance* will be based on the lesser of the *qualified payment amount* and billed charges;

and (3) the calculation of the *coinsurance* for *non-participating providers* of non-*emergency services* at a *hospital* or ambulatory surgical center which is a *participating provider*, in which case, the calculation of the *coinsurance* will be based on the *recognized amount*.* If *you* have a *deductible,* it is first subtracted from the allowed charge, *fee schedule*, or the *usual and customary amount*, the *recognized amount,* or the amount calculated for air ambulance services provided by a *non-participating provider* whichever is applicable, then the *coinsurance* percentage is applied to the remainder.

* If a *non-participating provider* provides non-*emergency health care services* at a *hospital* or ambulatory surgical center which is a *participating provider* and the *non-participating provider* has satisfied the notice and consent requirements described in Section IV.O. of this *SPD* entitled Balance Billing, then the *Plan* will pay for charges for such non-*emergency health care services* according to the terms of the *non-participating provider benefit* in the table in Section VI.J. and any amounts paid by *you* toward the *deductible* for charges for such non-*emergency health care services* will count toward the *deductible* for *non-participating providers*.

Benefits	***Participating Provider Plan* Payment**	***Non-Participating Provider Plan* Payment** **Note**: For *non-participating providers*, in addition to any *deductible* and *coinsurance, you* pay all charges that exceed the *usual and customary amount*, when applicable*.

C. Ambulance Services

• Ambulance services for an *emergency*	100% of *eligible charges* after the *deductible.*	Same as the *participating provider benefit* for *emergency* ambulance services.*
• Non-*emergency* transportation	100% of *eligible charges* after the *deductible.*	50% of *eligible charges* after the *deductible.**

* **Air ambulance services.** Covered air ambulance services provided by a *non-participating provider* are subject to the same *deductible* requirements that would apply if the services were provided by a *participating provider* of air ambulance services. The *deductible* requirements must be calculated as the lesser of the *qualifying payment amount* and the billed amount for the services.

The *Plan* covers ambulance service to the nearest *hospital* or medical center where initial care can be rendered for a medical *emergency*. Air ambulance transport to the nearest *hospital* that is able to render *medically necessary* care, is covered only when the condition is an acute medical *emergency* and is authorized by a *physician*.

The *Plan* also covers *emergency* ambulance (air or ground) transfer from a *hospital* not able to render the *medically necessary* care to the nearest *hospital* or medical center able to render the *medically necessary* care only when the condition is a critical medical situation and is ordered by a *physician* and coordinated with a receiving *physician*.

Prior notification is recommended for:

- Non-*emergency* ambulance service, from *hospital* to *hospital* when care for *your* condition is not available at the *hospital* where *you* were first admitted; and
- Non-*emergency* transfers by ambulance from a *hospital* to other facilities for subsequent covered care or from home to *physician* offices or other facilities for outpatient treatment procedures or tests when medical supervision is required en route.

Exclusions:

- Please see the section entitled "Exclusions."
- Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.

Benefits	*Participating Provider* *Plan* **Payment**	*Non-Participating Provider* *Plan* **Payment** **Note**: For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*.
D. Chiropractic Services	100% of *eligible charges.* *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*

Coverage includes chiropractic services to treat acute musculoskeletal conditions, by manual manipulation therapy. Diagnostic services are limited to *medically necessary* radiology. Treatment is limited to conditions related to the spine or joints.

Exclusions:

- Please see the section entitled "Exclusions."
- Routine maintenance chiropractic care.
- Blood, urine, or hair analysis related to chiropractic services.
- Performance of ultrasound, MRI, EMG, waveform and nuclear medicine diagnostic studies or other enhanced diagnostic imaging.
- Manipulation under anesthesia related to chiropractic services.

Benefits	*Participating Provider* ***Plan*** **Payment**	*Non-Participating Provider* ***Plan*** **Payment** **Note**: For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*.
E. Dental Services	The *Plan Administrator* considers dental procedures to be services rendered by a *dentist* or dental *specialist* to treat the supporting soft tissue and bone structure.	
	See "Office Visits" and "*Hospital* Services."	See "Office Visits" and "*Hospital* Services."

Accidental Dental Services. Treatment and repair for services required due to an accidental *injury* must be started within six months and completed within twelve months of the date of the *injury*. The *Plan* covers services to treat and restore damage done to a sound, natural tooth as a result of an accidental *injury*. Coverage is for external trauma to the face and mouth only. A sound, natural tooth is a tooth, including supporting structures, that is healthy and would be able to continue functioning for at least one year. Primary (baby) teeth must have a life expectancy of one year before loss.

Medically Necessary **Dental Services**. The *Plan* covers dental services, limited to dental services required for treatment of an underlying medical condition, e.g. removal of teeth to complete radiation treatment for cancer of the jaw, cysts and lesions. The *Plan* covers surgical extraction of impacted wisdom teeth.

Medically Necessary **Hospitalization for Dental Care**. *Eligible charges* are those *incurred* by a *covered person* who: (1) is a child under age five; (2) is severely disabled; or (3) has a medical condition, unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/*dentist* or dental *specialist* professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction, or hemophilia. Care must be directed by a *physician*, *dentist,* or dental *specialist*.

Exclusions:

- Please see the section entitled "Exclusions."
- Dental services covered under *your* dental plan.
- Preventive dental procedures.
- *Health care services* or dental services, orthodontia, and all associated expenses, except as stated in this section.
- *Health care services* or dental services for cracked or broken teeth that result from biting, chewing, disease, or decay.
- Dental implants.
- Prescriptions written by a *dentist* unless in connection with dental procedures covered under this *Plan*.
- *Health care services* or dental services related to periodontal disease.
- Occlusal adjustment or occlusal equilibration.
- Treatment of bruxism.

Benefits	***Participating Provider Plan* Payment**	***Non-Participating Provider Plan* Payment** **Note**: For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*. **NOTE:** *Non-participating providers* must have a Medicare provider number for their charges to be eligible for coverage.
F. Durable Medical Equipment (DME), Services, and Prosthetics	Wigs for hair loss resulting from a medical condition are limited to a maximum of one wig per *covered person* per *calendar year*.	
	100% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible.*
Diabetic supplies: Coverage includes over-the-counter diabetic supplies, syringes, blood and urine test strips and other diabetic supplies as *medically necessary*. Note: See "*Preventive Health Services"* section for coverage of glucose meters.	100% of *eligible charges* after the *deductible.*	50% of *eligible charges* after the *deductible.*

The *Plan* covers certain equipment and *health care services*, nutritional formulas, and enteral feedings, which may include; amino-acid based formulas, other oral nutritional and electrolyte substances; and special dietary treatment for phenylketonuria (PKU); ordered or prescribed by a *physician* and provided by DME/prosthetic vendors. For verification of eligible equipment and supplies, call Customer Service. *Benefits* are limited to the most cost-effective and *medically necessary* alternative. *Plan* payment for rental shall not exceed the purchase price unless the *Plan* has determined that the item is appropriate for rental only. The *Plan Administrator* reserves the right to determine if an item will be approved for rental or purchase.

The *Plan* also covers the following:

- Custom molded foot orthotics.
- *Medically necessary d*urable medical equipment, orthotics, and prosthetics.
- When *medically necessary*, therapeutic shoes for diabetes, prosthetic shoes, rehabilitative foot orthotics following surgery or trauma.

Exclusions:

- Please see the section entitled "Exclusions."
- Any durable medical equipment or supplies not listed as eligible on the *Plan's* durable medical list, or as determined by the *Plan Administrator*.
- Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage.
- Durable equipment necessary for the operation of equipment determined not to be eligible for coverage.
- Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use.
- Replacement or repair of items when damaged or destroyed by misuse, abuse, or carelessness, lost, or stolen.
- Duplicate or similar items.

- Hearing aids, devices to improve hearing and related fittings or *health care services*.
- Communication aids or devices; equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication board, or computer or electronic assisted communication.
- Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds.
- Vehicle/car or van modifications including, but not limited to, handbrakes, hydraulic lifts, and car carrier.
- Over-the-counter orthotics and appliances.
- Orthopedic shoes, except as covered under this *SPD*.
- Other equipment and supplies, and oral nutritional and electrolyte substances that the *Plan Administrator* determines are not eligible for coverage.
- Charges for sales tax, mailing or delivery.
- Upgrades to or replacement of any items that are considered *eligible charges* and covered under this *SPD*, unless the item is no longer functional and is not repairable.
- Glucose meters, blood pressure monitors, and peak flow meters are not covered under this section of this *SPD*. Please refer to the "*Preventive Health Care Services*" section of the *SPD* for coverage of these items.

Benefits	*Participating Provider* ***Plan* Payment**	*Non-Participating Provider* ***Plan* Payment**
G. *Emergency Services*	The emergency room *copayment* is waived if *you* are admitted within 24 hours for the same emergency condition treated in the emergency room.	
	100% of *eligible charges* for *emergency services* after a $250 *copayment* per visit. *Deductible* does not apply.	100% of the *out-of-network rate* after a $250 *copayment* per visit. *Deductible* does not apply.

You should be prepared for the possibility of a medical *emergency* by knowing *your participating provider's* procedures for "on call" and after regular office hours before the need arises. Determine the telephone number to call, which *hospital your participating provider* uses and other information that will help *you* act quickly and correctly. Keep this information in an accessible location in case a medical *emergency* arises.

If *you* have an *emergency* that requires immediate treatment, call 911 or go to the nearest emergency facility. If possible under the circumstances, *you* should telephone *your physician* or the clinic where *you* normally receive care. A *physician* will advise *you* how, when, and where to obtain the appropriate treatment.

Note: Services other than *emergency services* received in an emergency room are not covered. If *you* choose to receive non-*emergency services* in an emergency room, *you* are solely responsible for the cost of these services. See *emergency* under "Definitions of Terms Used".

Notwithstanding anything in this *SPD* to the contrary, the *Plan* shall cover *emergency services*, whether provided by a *participating provider* or a *non-participating provider*, without the need for any prior notification determination.

Covered services, whether provided by a *participating provider* or a *non-participating provider*, are subject to all of the *benefit* limitations set forth in this *SPD*. *You* should provide notice to the Utilization Management vendor of an admission to an inpatient facility within 48 hours or as soon as reasonably possible.

Exclusions:

- Please see the section entitled "Exclusions."
- Non-*emergency services* received in an emergency room.

Benefits	*Participating Provider Plan* Payment	*Non-Participating Provider Plan* Payment **Note**: For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*.
H. Home Health Services	Limited to 100 visits (4 hours of service = 1 visit) per *covered person* per *plan year* for home health services. Limited to 100 visits for palliative care (4 hours of service = 1 visit) per *covered person* per *plan year* if *you* are eligible to receive palliative care in the home but *you* are not homebound.	
• Home health care as an alternative to facility or clinic based care	100% of *eligible charges* after the *deductible.*	50% of *eligible charges* after the *deductible.*

NOTE: *Benefits* for *prescription drugs* administered or received during a home health care visit are described in the "*Prescription Drug* Services" section. All terms, conditions, limitations, and exclusions described in the "*Prescription Drug* Services" section of this *SPD* apply when *prescription drugs* are administered or received during a home health care visit.

The *Plan* covers skilled home health services that are directed by a *physician* and received from a licensed Home Health Care Agency. Services may include: *skilled care*; physical therapy; occupational therapy; speech therapy; respiratory therapy; home health care as an alternative to facility or clinic based care and other *medically necessary* therapeutic services that are rendered in *your* home.

In order for services to be received in *your* home, *you* must be *homebound*, or the *Plan Administrator* must determine the services are medically appropriate and the most cost effective to the *Plan*.

A *health care service* shall not be considered *skilled care* merely because it is performed by, or under the direct supervision of, a licensed registered nurse. Where a *health care service* (such as tracheotomy suctioning or ventilator monitoring or like services) can be safely and effectively performed by a non-medical person, or self-administered, without the direct supervision of a licensed registered nurse, the *health care service* shall not be regarded as *skilled care*, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of "blended" services (i.e., services that include skilled and non-skilled components) is covered under the *Plan*.

The *Plan* covers palliative care benefits if *you* are not *homebound* up to the visit limit stated above. Palliative care includes symptom management, education, and establishing goals of care.

Exclusions:

- Please see the section entitled "Exclusions."
- Companion and home care services, unskilled nursing services, services provided by *your* family or a person who shares *your* legal residence.
- *Health care services* and other services provided as a substitute for a primary caregiver in the home.
- *Health care services* and other services that can be performed by a non-medical person or self-administered.
- Home health aides, unless determined to be *medically necessary* by the *Plan Administrator*.
- *Health care services* and other services provided in *your* home for convenience.
- *Health care services* and other services provided in *your* home due to lack of transportation.
- *Custodial care.*
- *Health care services* classified as home health services provided at any site other than *your* place of residence.
- *Health care services* and other services rendered by *providers* unlicensed or not certified by the appropriate state regulatory agency.

Benefits	***Participating Provider Plan* Payment**	***Non-Participating Provider Plan* Payment** **Note**: For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*.
I. Hospice Care	100% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible.*

The *Plan* covers hospice services for terminally ill patients in a hospice program. The patient must meet the eligibility requirements of the program and elect to receive services through the hospice program. The services will be provided in the patient's home or hospice center, with inpatient care available when *medically necessary*. Hospice services are in lieu of curative or restorative treatment.

Eligibility. In order to be eligible to be enrolled in the hospice program, *you* must:

- Be terminally ill with *physician* certification of six months or less to live; and
- Have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than restorative treatment or treatment attempting to cure the disease or condition).

You may withdraw from the hospice program at any time.

Hospice services include the following services provided in accordance with an approved hospice treatment plan:

- Care provided in *your* home by an interdisciplinary hospice team (which may include a *physician*, nurse, social worker, and spiritual counselor) and home health aide services;
- One or more periods of continuous care provided in *your* home or in a setting that provides day care for pain or symptom management by a registered nurse, licensed practical nurse, or home health aide, when *medically necessary* as determined by the *Plan Administrator*;
- *Medically necessary* inpatient services;
- Respite care for caregivers in *your* home or in an appropriate setting. Respite care must be authorized in advance to give *your* primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain *you* at home.
- *Medically necessary* medications for pain and symptom management;
- Durable medical equipment when authorized in advance and determined by the *Plan Administrator* to be *medically necessary*.

Continuous care is defined as two to 12 hours of service per calendar day provided by a registered nurse, licensed practical nurse, or home health aide during a period of crisis in order to maintain *you* in *your* home when *you* are terminally ill.

Exclusions:

- Please see the section entitled "Exclusions."
- *Health care services* and other services provided by *your* family or a person who shares *your* legal residence.
- Respite or rest care except as specifically described in this section.

Benefits	***Participating Provider Plan* Payment**	***Non-Participating Provider Plan* Payment** **Note**: For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*, when applicable.*

J. *Hospital* Services

Outpatient *Hospital* Services, Ambulatory Surgical Center, or other Freestanding Outpatient Surgical Center	100% of *eligible charges* after the *deductible.*	50% of *eligible charges* after the *deductible.*
Outpatient *Hospital*, Partial *Hospital*, and Rehabilitation Services in a Day *Hospital* Program for Mental and Substance Use Related Disorders	100% of *eligible charges* after the *deductible.*	50% of *eligible charges* after the *deductible.*
• Telehealth and/or Virtual Visits	100% of *eligible charges. Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
Inpatient *Hospital* Services	**Note**: Each *covered person's confinement*, including that of a covered newborn child, is separate and distinct from the *confinement* of any other *covered person*. If *you* have *covered employee* only coverage, on the date of birth of a newborn, *you,* and *your* new *covered dependent(s)*, when enrolled, become subject to the terms and conditions of family coverage.	
	100% of *eligible charges* after the *deductible.*	50% of *eligible charges* after the *deductible.*
Inpatient *Hospital* and *Residential Treatment Facility Services* for Mental and Substance Use Related Disorders	100% of *eligible charges* after the *deductible.*	50% of *eligible charges* after the *deductible.*
Non-Routine Prenatal and Postnatal care received in a *Hospital*.	100% of *eligible charges* after the *deductible.*	50% of *eligible charges* after the *deductible.*

* In the case of *health care services* (other than *emergency services*) furnished by a *non-participating provider* with respect to a visit at a *hospital* or ambulatory surgical center which is a *participating provider*:

a) Unless the *non-participating provider* has satisfied the notice and consent requirements described in Section IV.O. of this *SPD* entitled Balance Billing, *your deductible* will be calculated as if the total amount charged for such non-*emergency health care services* were equal to the *recognized amount*.

b) If the *non-participating provider* has satisfied the notice and consent requirements, then the *Plan* will pay according to the terms of the *non-participating provider benefit* in the table above.

Notify the Utilization Management vendor of an admission to an inpatient facility within 48 hours or as soon as reasonably possible.

NOTE: *Benefits* for *prescription drugs* administered or received in an outpatient setting are described in the "*Prescription Drug* Services" section. All terms, conditions, limitations, and exclusions described in the "*Prescription Drug* Services" section of this *SPD* apply when *prescription drugs* are administered or received during an outpatient *hospital*, ambulatory surgical center, or other freestanding outpatient surgical center.

Some outpatient *hospital* services that are commonly performed in an office visit may be covered under the *Plan* as an office visit. Contact Customer Service if you have a question about *your Plan*.

Outpatient *Hospital*, Ambulatory Surgical Center, or other Freestanding Outpatient Surgical Center, Partial *Hospital* or *Day Treatment Services*. The *Plan* covers *health care services* authorized by a *physician* for the diagnosis or treatment of *sickness* or *injury* on an outpatient basis:

- Use of operating rooms or other outpatient departments, rooms or facilities;
- General nursing care, anesthesia, radiation therapy, *prescription drugs* or other medications administered during treatment, blood, and blood plasma and other diagnostic or treatment related outpatient services;
- Mental health and substance use related disorder services, such as:
  - An initial court-ordered exam for a covered dependent age 18 and under;
  - Outpatient professional services for evaluation and diagnostic services, crisis intervention, therapeutic services including psychiatric services and treatment of mental and nervous conditions;
  - Diagnosis and treatment of substance-related conditions including evaluations, diagnostic services, therapeutic services and psychiatric services;
  - Outpatient individual and group therapy;
  - Outpatient family therapy that is recommended by a designated provider treating a minor covered dependent child; and
  - Medication management.
- Telehealth and/or Virtual Visit services may include interactive audio, messaging, and video communications, permitting real time or asynchronous communication between a distant site *provider* of *health care services* and the *covered person*.
- Laboratory tests, pathology, and radiology; and
- *Physician* and other professional medical and surgical services rendered while an outpatient.
- *Medically necessary* genetic testing determined by *TPA* to be *covered services* if it is determined that: 1) the *covered person* displays clinical features, or is at direct risk of inheriting the mutation in question (presymptomatic); and 2) the result of a *covered person*'s screening test during prenatal care is abnormal, or the *covered person* has a high-risk pregnancy; and 3) the result of the test will directly impact the current treatment being delivered to the *covered person*; and 3) after history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.

The *Plan* also covers *preventive health care services*. These preventive services will be covered as shown in the *Preventive Health Care Services*, and/or the Preventive Contraceptive Methods and Counseling for Women sections of this *SPD*.

Inpatient Services. The *Plan* covers *health care services* authorized by a *physician* for the treatment of acute *sickness* or *injury* that requires the level of care only available in an *acute care facility, hospital,* or *residential treatment facility*. Inpatient services include, but are not limited to:

- Room and board;
- The use of operating rooms, intensive care facilities, newborn nursery facilities;
- General nursing care, anesthesia, radiation therapy, *prescription drugs* or other medications administered during treatment, blood, and blood plasma, and other diagnostic or treatment related inpatient services;
- *Physician* and other professional medical and surgical services;
- Mental health and substance use related disorder services;
- Laboratory tests, pathology, and radiology; and
- For a ventilator-dependent patient, up to 120 hours of services provided by a private-duty nurse or personal care assistant solely for the purpose of communication or interpretation for the patient.
- Inpatient private-duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.) when *medically necessary* and not *custodial* in nature and the *hospital's* Intensive Care Unit (ICU) is filled or the *hospital* has no ICU.

The *Plan* covers a semi-private room. *Benefits* for a private room are available only when the private room is *medically necessary* for a *sickness* or *injury* or if it is the only option available at the admitted facility. If *you* choose a private room when it is not *medically necessary*, *Plan* payment toward the cost of the room shall be based on the average semi-private room rate in that facility.

***Emergency Services* that Lead to an Inpatient Admission**

If *you* were incapacitated in a manner that prevented *you* from providing the notice described under "*Emergency Services*," or if *you* are a minor and *your* parent (or guardian) was not aware of *your* admission, then the time period begins when the incapacity no longer exists or when *your* parent (or guardian) is made aware of the admission. *You*

are considered incapacitated only when: (1) *you* are physically or mentally unable to provide the required notice; and (2) *you* are unable to provide the notice through another person.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict *benefits* for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the group health plan or health issuer may pay for a shorter stay if the attending *provider* (e.g., *your physician*, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans or health issuers may not set the level of *benefits* or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or health issuer may not, under federal law, require that a *physician* or other health care *provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain *providers* or facilities, or to reduce *your* out-of-pocket costs, *you* may be required to obtain pre-certification as described in the pre-certification provisions of the *Benefit* Schedule.

Exclusions:

- Please see the section entitled "Exclusions."
- Travel, transportation, other than ambulance transportation, and/or living expenses.
- Hospitalization, transportation, supplies, or medical services, including *physicians*' services furnished by the U.S. Government or by an institution operated by the U.S. Government, unless payment is required in accordance with applicable law.
- Nutritional counseling, except when:
  1. Provided during a *confinement*; or
  2. Provided in a *physician's* office, clinic system or *hospital* setting:
     i. For the diagnosis and treatment of diabetes; or
     ii. To a *covered person* who has been diagnosed by a *physician* with a chronic medical condition; or
     iii. As counseling that is treated as a *preventive health care service*.
- Private room, except when medically necessary or if it is the only option available at the admitted facility.
- Non-emergency ambulance service from hospital to hospital, such as transfers and admissions to hospitals performed only for convenience.
- Health care services to treat conditions that are cosmetic in nature.
- Orthoptics.
- Refractive surgery (e.g. lasik) for ophthalmic conditions that are correctable by contacts or glasses.
- Health care services and associated expenses for gender reassignment, except when medically necessary.
- Genetic testing and associated health care services, except as covered under this SPD.
- Hypnosis and chelation therapy, except chelation therapy will be covered when medically necessary for the treatment of heavy metal poisoning.
- Routine foot care, unless required due to blindness, diabetes, or peripheral vascular disease.
- Autopsies.
- Marital counseling, relationship counseling, family counseling except as otherwise described in this SPD, or other similar counseling or training services.
- Health care services to hold or confine a covered person under chemical influence when no medically necessary services are required, regardless of where the services are received (e.g. detoxification centers).
- Counseling, studies, health care services or confinements ordered by a court or law enforcement officer that are not determined to be medically necessary by the Plan Administrator.
- Treatment of compulsive gambling.
- Biofeedback.
- Surgical treatments and procedures to treat one-sided deafness.
- Growth hormone therapy prescribed for children due to short stature only, or for adults with no documented significant deficiency of growth hormone.
- Tobacco cessation intervention programs and associated *health care services*, except when covered as *preventive health care services.*

- Private-duty nursing care, except:
  - inpatient private-duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.) when *medically necessary* and not *custodial* in nature and the *hospital's* Intensive Care Unit (ICU) is filled or the *hospital* has no ICU, or
  - For a ventilator-dependent patient, up to 120 hours of services provided by a private-duty nurse or personal care assistant solely for the purpose of communication or interpretation for the patient.
- Treatment of cleft lip and cleft palate, except for such treatment of a covered dependent child if treatment is scheduled or started prior to the covered dependent child reaching age 19.

Benefits	***Participating Provider Plan* Payment**	***Non-Participating Provider Plan* Payment** **Note**: For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*.

K. *Infertility* Services

Diagnostic Services for *Infertility*	See "Office Visits" and "*Hospital* Services."	See "Office Visits" and "*Hospital* Services."
Surgical Correction of Physiological Abnormalities causing *Infertility*	See "Office Visits" and "Hospital Services."	See "Office Visits" and "Hospital Services."
Prescription drugs* for the treatment of *Infertility	Refer to the *Prescription Drug* Services section for a description of *your benefit*.	Refer to the *Prescription Drug* Services section for a description of *your benefit*.

This *Plan* covers the professional services necessary to diagnose *infertility* and the related tests, facility charges, and laboratory work related to eligible services. Services for the treatment of *infertility* are not eligible for coverage under this *Plan,* except for *prescription drugs* for the treatment of *infertility* and charges for surgical correction of physiological abnormalities causing *infertility***.**

Exclusions:

- Please see the section entitled "Exclusions."
- Treatment of male and female *infertility* and associated *health care services*.
- Artificially assisted technology such as, but not limited to, artificial insemination (AI) and intrauterine insemination (IUI).
- In vitro fertilization.
- Gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures.
- Intracytoplasmic sperm injection (ICSI).
- Sperm, ova, or embryo acquisition, retrieval, or storage.
- Reversal of voluntary sterilization.
- Adoption costs.

Benefits	*Participating Provider* ***Plan* Payment**	***Non-Participating Provider* *Plan* Payment** **Note**: For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*.
L. Office Visits	**Note:** Some services that may be provided during an office visit may be subject to the *deductible* and *out-of-pocket limit*, such as, but not limited to *specialty drugs* administered in an office setting, chemotherapy, radiation therapy, dialysis and certain services by *hospital*-based *physicians* that are billed as outpatient *hospital* and typically not delivered in an office setting.	
Sickness* or *Injury		
• Primary Care	100% of *eligible charges.* *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Specialty Care	100% of *eligible charges.* *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
Allergy Testing and Allergy Injections		
• Primary Care	100% of *eligible charges.* *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Specialty Care	100% of *eligible charges.* *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
Chemotherapy **Radiation Therapy**	100% of *eligible charges* after the d*eductible*.	50% of *eligible charges* after the *deductible.*
Laboratory and Pathology **X-Ray and Enhanced Radiology**		
• Primary Care	100% of *eligible charges.* *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Specialty Care	100% of *eligible charges.* *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
Dialysis	100% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible.*
Surgical Services		
• Primary Care	100% of *eligible charges.* *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Specialty Care	100% of *eligible charges.* *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
Telehealth and/or Virtual Visit	100% of *eligible charges.* *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
Telemedicine	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
Convenience Care Center	100% of *eligible charges.* *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
Urgent Care Center	100% of *eligible charges.* *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
Non-Routine Prenatal and Postnatal care.	100% of *eligible charges.* *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*

NOTE: *Benefits* for *prescription drugs* administered or received during an office visit are described in the "*Prescription Drug* Services" section. All terms, conditions, limitations, and exclusions described in the "*Prescription Drug* Services" section of this *SPD* apply when *prescription drugs* are administered or received during an office visit. The *Plan* covers office visits and *urgent care center*, *telemedicine*, and *designated convenience care center* visits related to diagnosis, care, or treatment of medical, mental health, and substance use related conditions, *sickness,* or *injury*:

- Outpatient professional services for evaluation, diagnosis, crisis intervention, therapy, including *medically necessary* group therapy, psychiatric services, and treatment of mental and nervous disorders; and
- Diagnosis and treatment of substance use related disorders, including evaluation, diagnosis, therapy, and psychiatric services.
- Laboratory tests, pathology, and radiology.
- Allergy injections.
- Contact lenses prescribed as *medically necessary* for the treatment of keratoconus. The lenses and fitting are *eligible charges* under the Durable Medical Equipment (DME) *benefit*. *Covered persons* must pay for lens replacement.
- Surgical service performed during an office visit.
- Oral surgery is covered for: 1) treatment of oral neoplasm and non-dental cysts; 2) fracture of the jaws; and 3) trauma to the mouth and jaws.
- Treatment of confirmed, existing temporomandibular disorder (TMD) and craniomandibular disorder (CMD). Dental services required to directly treat TMD or CMD are eligible. TMD splints are *eligible charges* under the Durable Medical Equipment (DME) *benefit*.
- Port wine stain elimination or maximum feasible treatment to lighten or remove the coloration.
- Diabetic outpatient self-management training and *educational* services.
- An *emergency* examination of a child ordered by judicial authorities.
- Telehealth and/or virtual visit services may include interactive audio and video communications, permitting real time communication between a distant site *provider* of *health care services* and the *covered person*.
- *Medically necessary* genetic testing determined by *TPA* to be *covered services* if it is determined that: 1) the *covered person* displays clinical features, or is at direct risk of inheriting the mutation in question (presymptomatic); and 2) the result of the test will directly impact the current treatment being delivered to the *covered person*; and 3) after history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.

The *Plan* also covers *preventive health care services*. These preventive services will be covered as shown in the *Preventive Health Care Services*, and/or the Preventive Contraceptive Methods and Counseling for Women sections of this *SPD*.

Exclusions:

- Please see the section entitled "Exclusions."
- Services, seminars, or programs that are primarily *educational* in nature.
- Health education, except when:
  1. Provided during an office visit for non-*preventive health care services*; or
  2. It is counseling which is treated as a *preventive health care service*.
- Tobacco cessation intervention programs and services, except when covered as *preventive health care services.*
- Nutritional counseling, except when:
  1. Provided during a *confinement*; or
  2. Provided in a *physician's* office, clinic system or *hospital* setting:
     i. For the diagnosis and treatment of diabetes; or
     ii. To a *covered person* who has been diagnosed by a *physician* with a chronic medical condition; or
     iii. As counseling that is treated as a *preventive health care service*.
- Professional sign language and foreign language interpreter services in a *provider's* office, except when arranged by the *provider's* office at the time of scheduling.
- Exams, other evaluations and/or services for employment, insurance, licensure, judicial or administrative proceedings or research, except as otherwise covered under this *SPD* or as *preventive health care services*.
- Charges for duplicating and obtaining medical records from *non-participating providers*, unless requested by the *Plan Administrator*.
- Genetic testing and associated *health care services*, except as covered under this *SPD*.
- Hypnosis and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
- Routine foot care, unless required due to blindness, diabetes, or peripheral vascular disease.

- Treatment of cleft lip and cleft palate, except for such treatment of a covered dependent child if treatment is scheduled or started prior to the covered dependent child reaching age 19.
- Vision therapy/orthoptics.
- *Health care services* provided by an audiologist that are not provided in an office setting.
- Marital counseling, relationship counseling, family counseling except as otherwise covered in this *SPD*, or other similar counseling or training services.
- Counseling, studies, *health care services* or *confinements* ordered by a court or law enforcement officer that are not determined to be *medically necessary* by the *Plan Administrator*.
- *Biofeedback*.
- Surgical treatments and procedures to treat one-sided deafness.
- Growth hormone therapy prescribed for children due to short stature only, or for adults with no documented significant deficiency of growth hormone.

Benefits	*Aetna Institutes of Excellence™ Provider*	*Non-Designated Transplant Network Provider* **Note**: For *non-designated transplant network providers*, including a *participating provider* that is not an Aetna Institutes of Excellence™ *provider*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*.
M. Organ and Bone Marrow *Transplant Services*	**See *Participating Provider Plan* Payment** column under "Office Visits" and *"Hospital* Services." for Aetna Institutes of Excellence™ provider *benefit*	See ***Non-Participating Provider Plan* Payment** column under "Office Visits" and *"Hospital* Services."

The *Plan* covers eligible *transplant services* that are pre-certified and determined by the *Plan Administrator* to be *medically necessary* and not *investigative*. *Transplant services* must be received at an Aetna Institutes of Excellence™ provider.

Coverage for organ transplants, bone marrow transplants and bone marrow rescue services is subject to periodic review. The *Plan Administrator* evaluates *transplant services* for therapeutic treatment and safety. This evaluation continues at least annually or as new information becomes available and it results in specific guidelines about *benefits* for *transplant services*. *You* may call the *TPA* at the telephone number listed inside the front cover for information about these guidelines.

Benefits may be available for the following transplants when the transplant meets the definition of a *covered service* and is not *investigative*:

- Bone marrow transplants and peripheral stem cell transplants with or without high dose chemotherapy.
- Heart transplants.
- Heart/lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney/pancreas transplants.
- Liver transplants.
- Pancreas transplants.
- Small bowel transplants.

Transplant coverage includes a private room and all related post-surgical treatment and drugs. The transplant related treatment provided shall be subject to and in accordance with the provisions, limitations, and other terms of this *SPD*.

Medical and *hospital* expenses of the donor are covered only when the recipient is a *covered person* and the transplant has been authorized in advance by the *Plan Administrator*. Treatment of medical complications that may occur to the donor are not covered.

Travel services are paid for by the *Plan* under the following circumstances:

- The *Covered Person* or the non-covered living donor must live more than 50 miles from the transplant center.
  - The *Plan* will pay for the travel and housing up to the maximum listed on the Schedule of Benefits.
  - Expenses will be paid for the following individuals:
    - The *Covered Person* who lives more than 50 miles from the transplant center.
    - One or two parents of the *Covered Person* if the *Covered Person* is a *Covered Dependent* child.
    - An adult to accompany the *Covered Person* if the *Covered Person* is not a *Covered Dependent* child.
    - The non-covered living donor who lives more than 50 miles from the transplant center.

Covered travel and housing expenses include the following:

- Airfare.
- Tolls and parking fees.
- Gas/mileage.
- Lodging at or near the transplant center including:
  - Apartment rental.
  - Hotel rental.
  - Applicable taxes.
  - Meals

Lodging for purposes of this Plan does not include private residences. Lodging reimbursement that is greater than $50 per person per day, may be subject to IRS codes for taxable income.

Exclusions:

- Please see the section entitled "Exclusions."
- *Health care services* related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures that are *investigative* for *your* condition.
- *Health care services* related to non-human organ implants.
- *Health care services* related to human organ transplants not specifically approved as *medically necessary* by the *Plan Administrator*.
- Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
- Treatment of medical complications to a donor after procurement of a transplanted organ.
- Computer search for donors.
- Private collection and storage of blood and umbilical cord/umbilical cord blood, unless related to scheduled future *covered services*.
- Travel services, except as covered under this *SPD*.
- *Health care services* for or in connection with fetal tissue transplantation, except for non-*investigative* stem cell transplants.
- Organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, excluding surgical implantation of U.S. Food and Drug Administration (FDA) approved ventricular assist devices.

Benefits	*Participating Provider* ***Plan*** **Payment**	*Non-Participating Provider* ***Plan*** **Payment** **Note**: For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*.
N. Physical Therapy, Occupational Therapy and Speech Therapy	See "Office Visits" and "*Hospital* Services."	See "Office Visits" and "*Hospital* Services."

The *Plan* covers office visits and outpatient physical therapy (PT), occupational therapy (OT) and speech therapy (ST) for *rehabilitative care* rendered to treat a medical condition, *sickness,* or *injury*. The *Plan* also covers outpatient PT, OT, and ST *habilitative therapy* for medically diagnosed conditions that have significantly limited the successful initiation of normal motor or speech development. PT, OT, and ST must be provided by or under the direct supervision of a licensed physical therapist, occupational therapist, or speech therapist for appropriate services within their scope of practice. OT and ST must be ordered by a *physician*, physician assistant or a certified nurse practitioner. Coverage is limited to *rehabilitative care* or *habilitative therapy* that demonstrates measurable functional improvement within a reasonable period of time.

Digital Physical Therapy. You may be eligible to participate in the programs and services of Gravie's digital physical therapy partner at no additional cost. More information is available by contacting Customer Service.

Exclusions:

- Please see the section entitled "Exclusions."
- In-person therapy visits provided in *your* home for convenience.
- Therapy for treatment of stuttering.
- Therapy for conditions that are self-correcting.
- Services which do not demonstrate measurable and sustainable improvement within two weeks to three months, depending on the physical and mental capacities of the individual.
- Voice training and voice therapy.
- Secretin infusion therapy.
- Sensory integration therapy when used for a reason other than the treatment of feeding disorders.
- Group therapy for PT, OT, and ST.
- *Health care services* for homeopathy and immunoaugmentative therapy.

Benefits	*Participating Provider* ***Plan*** **Payment**	*Non-Participating Provider* ***Plan*** **Payment**

O. *Prescription Drug* Services

Coverage includes *prescription drugs* dispensed at a pharmacy.

NOTE: This section does not cover or provide benefits for oral, injectable, or *prescription drugs* and insertable devices that are *preventive health care services* described in the "Preventive Contraceptive Methods and Counseling for Women" section of this *SPD.*

With the exception of contraceptive drugs for women, benefits for *specialty drugs* and/or injectable drugs, are as described in this section, regardless of the place of service where the *specialty drug* and/or injectable drug is dispensed or administered.

The *usual and customary amount* for *prescription drugs* obtained from a *non-participating provider* pharmacy is the cost of the generic equivalent of the *prescription drug* and the dispensing fee, or if a generic equivalent does not exist, the charge that the *Plan Administrator* determines is customary for such *prescription drug*.

If *you* request a brand name drug when a generic drug alternative is available, *you* are required to pay the difference in cost between the brand name and the generic drug, in addition to any applicable *copayments* or *out-of-pocket limit.*

The difference in cost between the brand name drug and the generic will not apply to the *out-of-pocket limit*, or to any *copayments*, that *you* are responsible for. When *you* have reached the *out-of-pocket limit*, *you* must still pay for the difference in the cost between the brand name and the generic drug.

Please see the *Preventive Health Care Services* section for coverage of *prescription drugs,* including certain insulin, on the Magellan Rx Standard Formulary Preventive Drug List.

• *Prescription drugs*, up to a 30-calendar day supply	**Generic drugs**: 100% of *eligible charge* per prescription unit or refill. *Deductible* does not apply. **Preferred Brand drugs**: 100% of *eligible charges* after a $75 *copayment* per prescription unit or refill. **Non-Preferred Brand drugs**: 100% of *eligible charges* per prescription unit or refill after the *deductible.* **Non-*Formulary* drugs**: Not covered.	Not covered.

• Mail order *prescription drugs*, up to a 90-calendar day supply	**Generic drugs**: 100% of *eligible charges* per prescription unit or refill. *Deductible* does not apply. **Preferred Brand drugs**: 100% of *eligible charges* after a $150 *copayment* per prescription unit or refill. **Non-Preferred Brand drugs**: 100% of *eligible charges* calendar prescription unit or refill after the *deductible*. **Non-*Formulary* drugs**: Not covered.	Not covered.
• *Prescription drugs* obtained from a Retail/Maintenance Drug Pharmacy, up to a 90-calendar day supply	**Generic drugs**: 100% of *eligible charges* per prescription unit or refill. *Deductible* does not apply. **Preferred Brand drugs**: 100% of *eligible charges* after a $150 *copayment* per prescription unit or refill. **Non-Preferred Brand drugs**: 100% of *eligible charges* per prescription unit or refill after the *deductible*. **Non-*Formulary* drugs**: Not covered.	Not covered.
• Diabetic supplies: Coverage includes over-the-counter diabetic supplies, syringes, blood and urine test strips, and other diabetic supplies as *medically necessary.* Note: See "*Preventive Health Services"* section for coverage of glucose meters.	100% of *eligible charges* after the *deductible*.	Not covered.

• *Specialty drugs* (excluding insulin) ➢ Up to a 30-calendar day supply ➢ *Specialty drugs* may be oral or injectable ➢ Must be purchased through a specialty pharmacy ➢ A list of specialty pharmacies may be obtained on the Magellan Rx website or by calling Customer Service ➢ The list of *specialty drugs* may be revised from time to time without notice. **Note:** *Prescription drugs* which Magellan Rx determines are *specialty drugs* will not be covered at the generic, preferred brand, non-preferred brand, mail order, or non-*formulary* benefit level. • Injectable drugs that are neither *specialty drugs* nor women's contraceptives, excluding insulin	100% of *eligible charges* after the *deductible.*	Not covered.

• *Prescription drugs* for treatment of *infertility* up to a 30-calendar day supply.	**Generic drugs**: 100% of *eligible charge* per prescription unit or refill. *Deductible* does not apply. **Preferred Brand drugs**: 100% of *eligible charges* after a $75 *copayment* per prescription unit or refill. **Non-Preferred Brand drugs**: 100% of *eligible charges* per prescription unit or refill after the *deductible.* **Non-*Formulary* drugs**: Not covered. ***Specialty drugs*:** 100% of *eligible charges* per prescription unit or refill after the *deductible*.	Not covered.

The *Plan Administrator* uses a drug *formulary* to determine which *prescription drugs*, including their generic equivalents, are covered. The *formulary* for Magellan is Magellan Rx Standard Formulary. The *formulary* is subject to periodic review and modification. For information, *you* may call Magellan Rx at the phone number listed on the inside front cover of this *SPD*.

You may obtain a Retail/Maintenance supply of ongoing, long-term *prescription drugs* through the Retail/Maintenance Drug Pharmacy Network, which includes participating retail pharmacies. *You* may contact Magellan Rx at the phone number listed on the inside front cover of this *SPD* to locate retail pharmacies participating in the Retail/Maintenance Drug Pharmacy Network.

For certain medical conditions, there is a need to manage the use of specific drugs before alternative (second line) drugs are prescribed for the same medical condition. This is known as step therapy. *Covered persons* in a step therapy program will need to meet the requirements of that program prior to receiving the second line drug. For information, *you* may call Magellan Rx at the phone number listed on the inside front cover of this *SPD*. Step therapy can apply to *formulary* or non-*formulary* drugs and brand or generic drugs. The Step Therapy list is subject to periodic review and modification by the *Plan*.

Compounded drugs will be covered only if obtained from a pharmacy that is *participating provider* provided that at least one active ingredient is a *prescription drug*. Payment for a *compounded drug* that has a commercially prepared product available that is identical to or similar to the *compounded drug* will be considered for coverage after documented failure of the commercially prepared product(s). A commercially prepared product is one that is available at the pharmacy in its final, usable form and does not need to be compounded at the pharmacy. The applicable *benefit* level will be applied. *Compounded drugs* containing any product that is excluded by the *Plan* will not be covered including dosages and route of administration that have not been approved by the FDA. *Compounded drugs* will be covered according to the *covered person's* pharmacy network *benefits*.

Prescription Drugs* covered as *Preventive Health Care Services. The *Plan* covers certain *prescription drugs* which are required to be covered without cost-sharing as *preventive health care services* under the *Affordable Care Act.* The *Plan's formulary* identifies these *prescription drugs* as being included in the "$0 Cost Share" tier and may be obtained by accessing the Magellan Rx member website or by calling Magellan Rx. More information regarding *benefits* for *prescription drugs* that are *preventive health care services* can be found under the "Preventive Contraceptive Methods and Counseling for Women" and "*Preventive Health Care Services*" sections of this *SPD*.

Biosimilar Drugs. If all of the following apply:

1. *you* or *your provider* request a *specialty drug* that is a biological product licensed by the FDA under section 351(a) of the Public Health Service Act (PHS Act), and
2. the FDA has determined another biological product to be biosimilar to the *specialty drug* that has been requested by *your provider*, and
3. The *Plan Administrator* has included such biosimilar product on its list of approved biosimilar drugs in relation to the *specialty drug* that has been requested by *your provider*,

then *you* must pay any applicable *out-of-pocket limit* for the *specialty drug* requested by *your provider* plus the difference in cost between the *specialty drug* requested by your *provider* and the biosimilar product that is on the *Plan Administrator's* list of approved biosimilar drugs.

Off-label use of drugs. Off-label use of drugs, provided that they are not *investigative,* may be covered in either of the following circumstances:

1. A drug is recognized as appropriate for cancer treatment in the National Comprehensive Cancer Network Drugs and Biologics Compendium; or

2. A drug is deemed appropriate for its proposed use by any authoritative compendia identified by the Medicare program, and/or in an article from a major peer reviewed medical journal, provided that such article uses generally acceptable scientific standards other than case-reports.

In addition, off-label use of drugs is only allowed if all of the following are met in addition to one of the above circumstances applying:

1. The off-label prescription follows all appropriate guidelines (e.g. dosage, age, ingestion, etc.) from the National Comprehensive Cancer Network Drugs and Biologics Compendium, applicable authoritative compendia or applicable major peer reviewed medical journal article; and

2. The drug is prescribed for the treatment of a diagnosed medical condition and is used consistent with the purpose of the prescription.

As with other health care services, off-label use of a drug must be *medically necessary*.

Prior authorization. Certain *prescription drugs* require prior authorization before *you* can have *your* prescription filled at the pharmacy. For information, you may call Magellan Rx at the phone number listed on inside cover of this *SPD*. These *prescription drugs* include, but are not limited to:

- *Prescription drugs* over:
  a. $300 if a *compounded drug*,
  b. $1,500 if a retail prescription; or
- *Specialty drugs*.
- *Prescription drugs* for the treatment of *infertility*.

For information, *you* may call the *TPA* at the phone number listed on the inside front cover of this *SPD*.

Magellan Value Max Program. *You* may be eligible to participate in the Magellan Value Max program if *you* are currently taking, or if *you* begin taking certain *specialty drugs*. This program will help *you* enroll in financial assistance programs offered by the manufacturer for *your* eligible *specialty drug*, with the goal of helping *you* avoid most out-of-pocket expenses for *your* therapy.

If *you* are eligible to participate in the program the Magellan Rx specialty pharmacy will contact *you* to help *you* enroll in the applicable financial assistance program for *your* medication if *you* are not already enrolled. Or, *you* can contact Magellan Rx Management by calling 800-424-0472 or logging onto www.magellanrx.com for information about sending *your* prescriptions for *your specialty drugs.*

If *you* decide not to enroll or if *you* disenroll in the program, *you* will be responsible for the full *deductible* and *coinsurance* for *specialty drugs* as defined in this *SPD.*

Exclusions:

- Please see the section entitled “Exclusions.”
- *Compounded drugs* that are being used for bio-identical hormone replacement therapy, unless otherwise covered.
- *Compounded drugs* received from a *non-participating provider.*
- Replacement of a *prescription drug* due to loss, damage, or theft.
- *Prescription drugs* or OTC drugs in the same classification of drugs as the following:
  1. Non-Sedating Antihistamines (NSAs).
  2. Non-steroidal Anti-Inflammatory drugs (NSAIDs).
  3. H2 antagonists (H2As).
  4. Proton Pump Inhibitors (PPIs).
- Over-the-counter drugs with or without a *physician’s* prescription, except as covered under this *SPD.*
- Over-the-counter home testing products, except as covered under this *SPD.*
- Drugs not approved by the FDA, drugs not approved by the FDA for a particular use (i.e. “off-label” use of drugs), except off-label use of drugs in accordance with the section entitled “Off-label use of drugs” or when the *Plan Administrator*, at its sole discretion, determines to include the drug on its *formulary* or approves coverage of the drug for the particular use.
- Take home drugs when dispensed by a *physician*.
- Weight loss drugs, including off-label use of drugs for weight loss unless in accordance with the section entitled “Off-label use of drugs.”
- *Prescription drugs* and over-the-counter drugs for tobacco cessation, except as covered as a *preventive health care service*
- Prescriptions written by a *dentist*, unless in connection with dental procedures covered under this *Plan*.
- Drugs used for *cosmetic* purposes.
- Unit dose packaging per request of the *covered person*.
- Injectable *prescription drugs* to treat sexual dysfunction.
- *Prescription drugs* if purchased by mail order through a program not administered by the *Plan's* pharmacy vendor.
- Non-FDA approved mechanism of delivery (e.g., medication that is FDA approved for oral use, but is being applied topically).
- Drugs that are given or administered as part of a drug manufacturer's study.
- Off-label use of drugs, determined to be *investigative*.
- Growth hormone therapy prescribed for children due to short stature only, or for adults with no documented significant deficiency of growth hormone.
- Oral, injectable and insertable contraceptives and contraceptive devices, except as covered as a *preventive health care service* in the Preventive Contraceptive Methods and Counseling for Women section of this *SPD.*
- *Specialty drugs* received from a *non-participating provider* pharmacy.
- Prescribed or non-prescribed vitamins or minerals including over-the-counter, unless covered as *preventive health care services*.

Benefits	*Participating Provider* ***Plan* Payment**	*Non-Participating Provider* ***Plan* Payment** **Note**: For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*.

P. Preventive Contraceptive Methods and Counseling for Women

The *Plan* covers preventive contraceptive methods and counseling services by female *covered persons* as described in the Preventive Health Care Services Schedule ("Schedule"). The Schedule, which includes preventive contraceptive methods and counseling services for women provided by the *Affordable Care Act*, is available on the *TPA's* member website or by calling Customer Service.

This coverage includes the full range of Food and Drug Administration approved contraceptive methods for women with reproductive capacity, including women's contraceptive drugs, devices, and delivery methods obtained from a retail pharmacy, mail order pharmacy, or received at a *provider's* office.

Women's prescription contraceptives received at a retail pharmacy, mail order pharmacy, or retail/maintenance drug pharmacy:

• Generic oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law up to a 30-calendar day supply from a retail pharmacy, up to a 90-calendar day supply from a mail order pharmacy, and up to a 90-calendar day supply from a retail/maintenance drug pharmacy; and • Brand name oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which no generic alternative exists up to a 30-calendar day supply from a retail pharmacy, and up to a 90-calendar day supply from a mail order pharmacy, and up to a 90-calendar day supply from a retail/maintenance drug pharmacy.	**Retail pharmacy:** 100% of *eligible charges*. *Deductible* does not apply. **Mail order pharmacy:** 100% of *eligible charges*. *Deductible* does not apply. **Retail/maintenance drug pharmacy:** 100% of *eligible charges*. *Deductible* does not apply.	Not covered

• Brand name oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists up to a 30-calendar day supply from a retail pharmacy, and up to a 90-calendar day supply from a mail order pharmacy, and up to a 90-calendar day supply from a retail/maintenance drug pharmacy.	**Retail pharmacy:** **Preferred Brand drugs**: 100% of *eligible charges* after a $75 *copayment* per 30 calendar-day prescription unit or refill. **Non-Preferred Brand drugs**: 100% of *eligible charges* per 30-calendar day prescription unit or refill after the *deductible*. **Non-*Formulary* drugs**: Not covered. **Mail order pharmacy:** **Preferred Brand drugs**: 100% of *eligible charges* after a $150 *copayment* per 90-calendar day prescription unit or refill. **Non-Preferred Brand drugs**: 100% of *eligible charges* per 90-calendar day prescription unit or refill after the *deductible.* **Non-*Formulary* drugs**: Not covered. **Retail/maintenance drug pharmacy:** **Preferred Brand drugs**: 100% of *eligible charges* after a $150 *copayment* per 90-calendar day prescription unit or refill. **Non-Preferred Brand drugs**: 100% of *eligible charges* per 90-calendar day prescription unit or refill after the *deductible.* **Non-*Formulary* drugs**: Not covered.	Not covered.

Women's prescription contraceptives, sterilization procedures, and *covered person* education received at a *provider's* office:		
• Generic injectable, implantable, and insertable contraceptives that require a prescription under applicable law; and • Brand name injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which no generic alternative exists.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Brand name injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists.	100% of *eligible charge* after the *deductible.*	50% of *eligible charges* after the *deductible.*
• Sterilization procedures, excluding the reversal of sterilization procedures.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• *Covered person* education and counseling about contraceptive methods.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*

If *you* or *your provider* request a brand name women's contraceptive that requires a prescription under applicable law when a generic alternative is available, *you* are required to pay the difference in cost between the brand name and the generic contraceptive, in addition to any applicable *copayments* or *coinsurance*.

The difference in cost between the brand name contraceptive and the generic will not apply to the *out-of-pocket limit,* or to any *copayments* that *you* are responsible for. When *you* have reached the *out-of-pocket limit*, *you* must still pay for the difference in the cost between the brand name and the generic contraceptive.

Exclusions:

- Please see the section entitled "Exclusions."
- Abortions are not covered under this section of this *SPD*.
- Non-prescribed over-the-counter contraceptives, including condoms, spermicides, and emergency contraceptives.
- Hysterectomies are not covered under this section of this *SPD*.
- Anesthesia and facility services related to sterilization procedures performed during other surgical procedures such as Cesarean section birth, gall bladder removal, and abdominal hernia repair are not covered under this section of this *SPD*.
- Reversal of sterilization procedures.
- Non-*preventive health care services* are not covered under this section of this *SPD*.

Benefits	*Participating Provider* ***Plan*** **Payment**	*Non-Participating Provider* ***Plan*** **Payment**
Q. *Preventive Health Care Services*	The *Plan* covers preventive services required by the *Affordable Care Act.* These services and their frequency and time frames are stated in the Preventive Health Care Services Schedule ("Schedule"). The Schedule may be amended, from time to time, on a prospective basis, and is available by contacting Customer Service.	
The Schedule includes certain routine services such as: • Counseling for certain conditions. • Routine immunizations. • Routine laboratory tests, pathology, and radiology. • Routine physical examinations. • Routine screenings for certain cancers and certain other conditions. **Note**: If any of the services listed above are prenatal or child health supervision services, see below for further benefit information.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Prescribed preventive medications required under the *Affordable Care Act.* **NOTE:** For a list of prescribed preventive medications that are required under the *Affordable Care Act*, please refer to Magellan Rx Standard Formulary at the website located on the inside cover of this SPD or by calling Customer Service.	100% of *eligible charges*. *Deductible* does not apply.	Not covered.
• Tobacco cessation intervention programs. ✓ Two designated tobacco cessation intervention program attempts per *covered person* per *calendar year*, limited to four counseling sessions per attempt;	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*

✓ Tobacco cessation *prescription drugs* and prescribed over-the-counter (OTC) medications when used in connection with or separate from designated tobacco cessation counseling program attempts, are limited to a maximum of 31-calendar days per prescription or refill per *covered person* and a total 93-calendar day supply per *covered person* per attempt for up to two attempts per *covered person* per *calendar year*.	100% of *eligible charges*. *Deductible* does not apply.	Not covered.

***Preventive Health care services* that are in Addition to Those Required by the *Affordable Care Act*:**

• Routine eye examination limited to one exam per *covered person* per *calendar year*.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Routine hearing examination limited to one exam per *covered person* per *calendar year.*	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Routine prenatal care services.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• One routine postnatal care exam that includes a health exam, assessment, education, and counseling provided during the period immediately after childbirth.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Child health supervision services (as defined below).	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Surveillance tests for ovarian cancer for women, including CA-125 serum tumor marker testing, transvaginal ultrasound, pelvic examination, or other proven ovarian cancer screening tests for women who are at risk for ovarian cancer due to family history or testing positive for BRCA1 or BRCA2 mutations.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*

• Prostate-specific antigen blood tests and digital rectal examinations to screen for prostate cancer for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Insulin on Magellan Rx Standard Formulary Preventive Drug list for up to a 31-calendar day supply for one type of insulin agent per prescription or refill. **NOTE:** For a list of insulins that are free under the expanded Preventive Rx list, please refer to Magellan Rx Standard Formulary at the website located on the inside cover of this SPD or by calling Customer Service	100% of *eligible charges*. *Deductible* does not apply.	Not covered.
• Blood pressure monitor for *covered persons* diagnosed with hypertension.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Peak flow meter for *covered persons* diagnosed with asthma.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Glucose meter for *covered persons* diagnosed with diabetes.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Retinopathy screening for *covered persons* with diabetes.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Hemoglobin A1c testing for *covered persons* diagnosed with diabetes.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• International Normalized Ratio (INR) testing for *covered persons* diagnosed with liver disease or bleeding disorders.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*
• Low-density Lipoprotein (LDL) testing for *covered persons* diagnosed with heart disease.	100% of *eligible charges*. *Deductible* does not apply.	50% of *eligible charges* after the *deductible.*

Female *covered persons* may obtain annual preventive health examinations and prenatal screenings from obstetricians and gynecologists in the *participating provider* network, without a referral from another *physician* or prior approval from the *Plan*.

Child health supervision services includes pediatric preventive services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations, up to age 18. Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from

12 months to 24 months, and once a year from 24 months to 72 months. Please refer to the *Affordable Care Act Preventive Health Care Services* Schedule to determine if additional coverage is available.

Notes:

- Non-*preventive health care services* are not covered under this section of the *SPD*.
- Non-routine *health care services*, including but not limited to non-routine prenatal services, are not covered under this section of the *SPD*.

Exclusions:

- Please see the section entitled "Exclusions."
- Any *health care service* performed during or in conjunction with an annual or periodic wellness exam that exceeds the services described in this section of the *SPD*.
- Electronic cigarettes, e-cigarettes, personal vaporizers, and similar forms of nicotine delivery systems.
- Tobacco cessation intervention programs and *health care services*, except as covered under the *SPD*.
- *Prescription drugs* and prescribed OTC drugs for tobacco cessation, except as covered under the *SPD.*

Benefits	*Participating Provider* ***Plan*** **Payment**	*Non-Participating Provider* ***Plan*** **Payment** **Note**: For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*.
R. *Reconstructive* Surgery	See "Office Visits" and "*Hospital* Services."	See "Office Visits" and "*Hospital* Services."

The *Plan* covers *medically necessary reconstructive* surgery due to *sickness*, accident, or congenital anomaly that is incidental to or follows surgery resulting from injury, *sickness,* or other diseases of the involved part, or when such surgery is performed on a covered dependent child because of a congenital disease or anomaly which has resulted in a functional defect as determined by the attending *physician*. *Eligible charges* include eligible *hospital*, *physician*, laboratory, pathology, radiology, and facility charges. Contact Customer Service to determine if a specific procedure is covered.

Reconstructive surgery following a mastectomy includes the following:
- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of mastectomy, including lymphedemas.

Health care services will be determined in consultation with *you* and the attending *physician*. Such coverage will be subject to *copayments*, *out-of-pocket limit, deductibles, coinsurance,* and other *Plan* provisions.

Statement of Rights Under the Women's health and Cancer Rights Act

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

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

Such coverage may be provided subject to the same annual deductibles and coinsurance and other Plan provisions as may be deemed appropriate and as are consistent with those established for other medical and surgical benefits under the Plan. Please refer to your Summary of Benefits for a full description of coverage under the Plan.

Exclusions:

- Please see the section entitled "Exclusions."
- *Health care services* to treat conditions that are *cosmetic* in nature.

Benefits	*Participating Provider* ***Plan*** **Payment**	*Non-Participating Provider* ***Plan*** **Payment** **Note**: For *non-participating providers*, in addition to any *deductible* and *coinsurance*, *you* pay all charges that exceed the *usual and customary amount*.
S. *Skilled Nursing Facility* Services	Coverage is limited to a maximum of 120 days per *covered person* per *calendar year*.	
	100% of *eligible charges* after the *deductible.*	50% of *eligible charges* after the *deductible.*

The *Plan* covers the eligible *skilled nursing facility* services for post-acute treatment and *rehabilitative care* of a *sickness* or *injury*. These services must be directed by a *physician* and authorized in advance by the *Plan Administrator*. Please follow the pre-certification procedure described in Section VI., *Benefit* Schedule, for the procedure *you* must follow.

Skilled nursing facility services include room and board, daily skilled nursing, and related services. The *Plan Administrator* determines when care no longer meets criteria for coverage.

The *Plan* covers a semi-private room. *Benefits* for a private room are available only when the private room is *medically necessary* for a *sickness* or *injury* or if it is the only option available at the admitted facility. If *you* choose a private room when it is not *medically necessary*, *Plan* payment toward the cost of the room shall be based on the average semi-private room rate in that facility. Only services that qualify as reimbursable under Medicare are *eligible charges*.

Exclusions:

- Please see the section entitled "Exclusions."
- Hospitalization, transportation, supplies, or medical services, including *physicians*' services furnished by the U.S. Government or by an institution operated by the U.S. Government, unless payment is required in accordance with applicable law.
- Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
- Respite or *custodial care*.

VII. Exclusions

Please note that exclusions listed under any category of *health care services* in Section VI. *Benefit* Schedule shall apply to all *health care services* regardless of the categories in which the exclusions appear. The exclusions in this Section VII. also apply to all *health care services*.

Many exclusions are interrelated so please read this entire section.

The *Plan* will not cover charges *incurred* for any of the following services:

1. *Health care services* that the *Plan Administrator* determines are not *medically necessary*, unless the specific terms of a *participating provider's* written agreement with the national network vendor applicable to the *Plan* precludes application of the exclusion.

2. *Health care services* received before coverage under this *Plan* begins or after *your* coverage under this *Plan* ends.

3. *Health care services* that the *Plan Administrator* determines are *investigative* and associated expenses, unless the specific terms of a *participating provider's* written agreement with the national network vendor applicable to the *Plan* precludes application of the exclusion.

4. *Health care services* not directly related to *your* care.

5. *Health care services* ordered or rendered by *providers* or para-professionals unlicensed by the appropriate state regulatory agency.

6. *Health care services* not rendered in the most cost-efficient setting or manner appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate.

7. Charges for *health care services* determined to be duplicate services by the *Plan Administrator*.

8. Charges that exceed the *usual and customary amount* for *health care services* received from *non-participating providers*, including *non-participating provider* pharmacies.

9. *Health care services* prohibited by law or regulation, or illegal under applicable laws.

10. Charges for *health care services* that are eligible for payment under any insurance policy, including auto insurance, or under a Workers' Compensation law, employer liability law or any similar law.

11. Non-*emergency* services received outside the United States.

12. Vision lenses, eyeglasses, frames, and their related fittings.

13. Routine eye examinations, except as covered under this *SPD*.

14. Routine hearing examinations, except as covered under this *SPD*.

15. Contact lenses and their related fittings, except when prescribed as *medically necessary* for the treatment of keratoconus.

16. *Health care services* or items for personal comfort or convenience.

17. Any *health care services* provided by a relative (i.e., a spouse, or a parent, brother, sister, or child of the *covered employee* or of the *covered employee's* spouse) or anyone who customarily lives in the *covered employee's* household.

18. *Health care services* provided by massage therapists, doulas, and personal trainers.

19. *Health care services* provided by providers who have not completed professional level education and licensure as determined by the *Plan Administrator*.

20. *Health care services* for the treatment of sexual dysfunction, except as otherwise covered in this *SPD*.

21. Sexual dysfunction *prescription drugs*, unless otherwise covered in this *SPD* or approved for other use by any authoritative compendia identified by the Medicare program, and/or in an article from a major peer reviewed medical journal, provided that such article uses generally acceptable scientific standards other than case-reports.

22. Charges for medical services that are paid or payable under any auto insurance policy, which covers the *covered person*, or for which the *covered person* is required by law to enroll.

23. Procedures that are generally *cosmetic*, or for convenience or comfort reasons, as listed on the *Plan's* Cosmetic Procedures Policy. This policy may be obtained by calling Customer Service.

24. *Orthognathic surgery*.

25. Massage therapy.

26. Alternative therapies such as aromatherapy and reflexology.

27. *Vocational rehabilitation*.

28. Drugs, medical devices, or therapies that are approved only for *compassionate use* by the U.S. Food and Drug Administration.

29. Homeopathic or naturopathic medicine, including dietary supplements.

30. Holistic medicine and services, including dietary supplements.

31. Elective abortion, except in situations where the life of the mother would be endangered if the fetus is carried to full term.

32. Acupuncture.

33. Charges billed by *providers* that are not in compliance with generally accepted guidelines established by the Centers for Medicare & Medicaid Services (CMS) and/or the *TPA's* policies.

34. *Health care services* for *sickness* or *injury* sustained:
    - While engaging in or the attempt to engage in a felony act, whether or not the individual is formally charged or convicted of such an act. This exclusion does not apply to any *sickness* or *injury* that is a result of an act of domestic violence or results from a medical condition, such as alcoholism.
    - While voluntarily participating in a riot, insurrection, or civil disobedience.
    - While in a war or any act of war. "War" means declared or undeclared war and includes acts of terrorism.

35. *Sickness* or *injury* that results from self-inflicted *injury* (other than suicide or attempted suicide). This exclusion does not apply to any *sickness* or *injury* that is a result of an act of domestic violence or results from a medical condition, such as depression.

36. *Health care services* including facility charges performed in a *non-participating provider* free-standing birth center unattached to a *hospital* facility.

37. Costs associated with *clinical trials* that are not *routine patient costs.*

38. Non-*emergency health care services* performed directly in connection with the performance of a non-covered *health care service.*

39. *Health care services* and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure, and employment, and when such services are not preventive care or otherwise *medically necessary*, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for driving under the influence/driving while intoxicated, competency evaluations, and adoption studies.

40. Services provided to *you* if *you* also have other primary insurance coverage for those services and *you* do not provide the *Plan* with the necessary information to pursue coordination of benefits, as required under this *SPD.*

41. Halfway houses, extended care facilities or comparable facilities, foster care, adult foster care, and family child care.

42. Sterilization reversals.

43. Cochlear implants.

44. Nutritional and food supplements, except as covered under this *SPD*.

45. *Health care services* for maternity labor and delivery in the home.

46. Health club memberships.

47. Recreational, *educational*, or self-help therapy or items primarily *educational* in nature or for vocation, comfort, convenience, or recreation. Recreational therapy is therapy provided solely for the purpose of recreation, including, but not limited to: a) physical therapy or occupational therapy to improve athletic ability, and b) braces or guards to prevent sports injuries.

48. Weight loss drugs, including off-label use of drugs for weight loss unless in accordance with the section entitled "Off-label use of drugs."

49. Any weight loss programs and related *health care services* that are not otherwise covered as *preventive health care services*.

50. Cannabis/Marijuana, except medical cannabis/marijuana when provided by *providers* licensed by applicable state law to sell medical cannabis/marijuana.

51. *Health care services* related to surrogate pregnancy for a person who is not a *covered person* under this *SPD*.

52. *Health care services* and associated expenses for gender reassignment, except when *medically necessary*.

53. Costs, charges, fees, and other losses for non-*health care services*.

54. *Bariatric surgeries*, including preoperative procedures, initial procedures, surgical revisions, and subsequent procedures.

55. Services provided during a telehealth and/or virtual visit for the sole purpose of: scheduling appointments; filling or renewing existing prescriptions; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; services that would similarly not be charged for in an onsite medical office visit; telephone conversations, e-mails, or facsimile transmissions between licensed health care *providers*; or e-mails, or facsimile transmissions between a licensed health care *provider* and a patient.

56. *Health care services* and supplies not ordered by a *provider,* such as but not limited to, cholesterol testing, glucose testing and mammograms unless specifically listed in the *Plan's* schedule of *Preventive Health Care Services* or provided by a *participating provider.*

VIII. Ending *Your* Coverage

Your coverage will terminate on the earliest of the following dates:

- The date the *Plan* is terminated;
- The end of the month in which the *covered employee* retires;
- The end of the month in which your eligibility under the Plan ends;
- The end of the month in which *your* written request is received to terminate coverage due to *your* enrollment in Medicare or another group health plan;
- For a dependent, the end of the month in which *your* written request is received to terminate *your* dependent's coverage due to *your* dependent's enrollment in Medicare or another group health plan;
- When *you* do not make *your* required *contribution* for coverage under the *Plan*. Termination will be retroactive to the last day for which *your* required *contribution* has been timely received; or
- The date *you*, or someone acting on *your* behalf, have performed an act or practice that constitutes fraud or made an intentional misrepresentation (including an omission) of material fact under the terms of the *Plan*.
- The end of the month following the date *you* enter active military duty for more than 31 days. Upon completion of active military duty, contact the Employer for reinstatement of coverage.
- The date of the death of the *covered person*. In the event of the *covered employee's* death, coverage for the *covered employee's* dependents will terminate the end of the month in which the *covered employee's* death occurred.
- For a spouse, the end of the month following the date of divorce.
- For a dependent domestic partner in the event that this *SPD* covers dependent domestic partners, the end of the month in which the individual no longer meets the criteria to be a dependent domestic partner.
- When the maximum period for coverage under COBRA Continuation Coverage expires for a *covered person*.
- For a child who is entitled to coverage through a QMCSO, the end of the month in which the earliest of the following occurs:
  a. The QMCSO ceases to be effective; or
  b. The child is no longer a child as that term is used in *ERISA*; or
  c. The child has immediate and comparable coverage under another plan; or
  d. The *covered employee* who is ordered by the QMCSO to provide coverage is no longer eligible as determined by the Employer; or
  e. The Employer terminates family or dependent coverage; or
  f. The relevant premium or *contribution* toward the premium is last paid.

For a covered dependent child, coverage will terminate the end of the month in which the child is no longer eligible as a *covered dependent*. If *your* covered dependent child is disabled, coverage will end the end of the month in which the covered dependent child marries or is no longer disabled.

IX. Leaves of Absence

A. Family and Medical Leave Act (FMLA)

If *you* are absent from work due to an approved family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), coverage may be continued for the duration of the approved leave of absence as if there was no interruption in employment. Such coverage will continue until the earlier of the expiration of such leave or the date *you* notify the Employer that *you* do not intend to return to work. *You* are responsible for all required *contributions*.

If *you* do not return after an approved leave of absence, coverage may be continued under the "COBRA Continuation Coverage" section, provided that *you* elect to continue under that provision. If *you* return to work immediately following *your* approved FMLA leave, no new *waiting periods* will apply.

FMLA applies to employees of a covered employer that work at a worksite within 75 miles of where that employer employs at least 50 employees.

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

Continuation of *Benefits*. *Covered employee*s who are absent due to service in the uniformed services and/or their *covered dependent*s may continue coverage pursuant to USERRA for up to 24 months after the date the *covered employee* is first absent due to uniformed service duty.

Eligibility. A *covered employee* is eligible for continuation under USERRA if the *covered employee* is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

*Covered dependent*s who have coverage under the *Plan* immediately prior to the date of the *covered employee's* covered absence are eligible to elect continuation under USERRA.

Upon the *covered employee's* return to work immediately following the *covered employee's* leave under USERRA, no new *waiting periods* will apply.

Premium Payment. If continuation of *Plan* coverage is elected under USERRA, the *covered employee* or *covered dependent* is responsible for payment of the applicable cost of coverage. If the *covered employee* is absent for not longer than 31 calendar days, the cost will be the amount the *covered employee* would otherwise pay for coverage. For absences exceeding 31 calendar days, the cost may be up to 102% of the cost of coverage under the *Plan*. This includes the *covered employee's* share and any portion previously paid by the Employer.

Duration of Coverage. Elected continuation coverage under USERRA will continue until the earlier of:

1. Twenty-four months, beginning the first day of absence from employment due to service in the uniformed services;

2. The day after the *covered employee* fails to apply for or return to employment as required by USERRA, after completion of a period of service;

3. The early termination of USERRA continuation coverage due to the *covered employee's* court-martial or dishonorable discharge from the uniformed services; or

4. The date on which this *Plan* is terminated.

The continuation available under USERRA does not affect continuation available under "COBRA Continuation Coverage." *Covered employee*s should contact their Employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the Employer of any changes in marital status or a change of address.

Return to Work Requirements. Under USERRA a *covered employee* is entitled to return to work following an honorable discharge as follows:

1. Less than 31 days service: By the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight-hour rest period.

2. Thirty-one to 180 days: The *covered employee* must apply for reemployment no later than 14 days after completion of military service.

3. One hundred and eighty-one days or more: The *covered employee* must apply for reemployment no later than 90 days after completion of military service.

4. Service-connected *injury* or illness: Reporting or application deadlines are extended for up to two years for persons who are hospitalized or convalescing.

C. Michelle's Law

Under *Michelle's Law*, group health *plans* and health insurers are prohibited from terminating the coverage of a student dependent whose enrollment in a *plan* requires student status at a postsecondary educational institution, if the student status is lost because of a qualifying *Medically Necessary Leave of Absence*.

Michelle's Law applies to a group health plan or related insurance coverage only if the *plan* or insurer receives written certification by the student dependent's treating physician stating that (1) the child is suffering from a serious illness or injury and (2) the Leave of Absence (or other change in enrollment) is *Medically Necessary*.

A student dependent is one who, regarding group health *plan* or health insurance coverage is both:

1. A dependent child, under the *plan*'s or coverage's terms, of a participant or beneficiary in the *plan* or coverage.
2. Was enrolled in the *plan* or coverage, on the basis of being a student at a postsecondary educational institution, immediately before the first day of the *Medically Necessary Leave of Absence* involved.

X. COBRA Continuation Coverage

The *covered employee*, the covered spouse and covered dependent children may continue coverage under the *Plan* when a qualifying event occurs. *You* may elect COBRA for *yourself* regardless of whether the *covered employee* or other eligible dependents in *your* family elect COBRA. A *covered employee* and a covered spouse may elect COBRA on behalf of each other and/or their covered dependent children. If a loss of coverage qualifying event occurs:

1. In certain cases, the covered employee may continue his or her coverage and may also continue coverage for his or her covered spouse, covered dependent children, domestic partners and covered dependent children of the domestic partner when coverage would normally end

2. In certain cases, the covered spouse and covered dependent children may continue coverage when coverage would normally end. A domestic partner and the covered dependent children of the domestic partner may not continue coverage except as a *dependent* of a *covered employee* at the option of the *covered employee*;

3. Coverage will be the same as that for other similar *covered persons*; and

4. Continuation coverage under this *Plan* ends when this *Plan* terminates or as explained in detail on the following Continuation Chart. The *covered employee*, the covered spouse and covered dependent children may, however, be entitled to continuation coverage under another group health plan offered by the Employer. *You* should contact the Employer for details about other continuation coverage.

For additional information about *your* rights and obligations under the *Plan* and/or federal COBRA law, *you* should contact the Employer, which is the official *Plan Administrator*.

Qualifying Events

1. Loss of coverage under this *Plan* by the *covered employee* due to one of these events:
   a. Voluntary or involuntary termination of employment of the *covered employee* for reasons other than "gross misconduct."
   b. Reduction in the hours of employment of the *covered employee*.
   c. Layoff of the *covered employee*.
   d. Leave of absence of the *covered employee*.
   e. Early retirement of the *covered employee*.

2. Loss of coverage under this *Plan* by the covered spouse and/or covered dependent children due to one of these events:
   a. Voluntary or involuntary termination of employment of the *covered employee* for reasons other than "gross misconduct."
   b. Reduction in the hours of employment of the *covered employee*.
   c. Layoff of the *covered employee*.
   d. Leave of absence of the *covered employee*.
   e. Early retirement of the *covered employee*.
   f. *Covered employee* becoming entitled to Medicare.
   g. Divorce or legal separation of the *covered employee*.
   h. Death of the *covered employee*.

3. Loss of coverage under this *Plan* by the covered dependent child due to loss of "dependent child" status under this *Plan*.

4. Loss of coverage under this *Plan* due to the bankruptcy of the Employer under Title XI of the United States Code. For purposes of this qualifying event (bankruptcy), a loss of coverage includes a substantial elimination of coverage that occurs within one year before or after commencement of the bankruptcy proceeding. Applies to the covered retiree, the covered spouse and covered dependent children.

Required Procedures

When the initial qualifying event is death, termination of employment or reduction in hours (including leave of absence, layoff, or retirement), or Medicare entitlement of the *covered employee*, or the bankruptcy of the Employer, the *Plan Administrator* will offer continuation coverage to qualified *covered persons*. *You* do not need to notify the *Plan Administrator* of these qualifying events. However, for other qualifying events including divorce or legal

separation of the *covered employee* and loss of dependent child status, COBRA continuation is not available to *you* if *you* do not provide timely, written notice to the *Plan Administrator* as required below by the *Plan*. *You* must also provide timely, written notice to the *Plan Administrator* of other events, such as a Social Security disability determination or second qualifying events, in order to be eligible for an extension of COBRA continuation as required by the *Plan* as stated in this section. To elect COBRA, *you* must make a timely, written election as required by the *Plan* as stated in this section.

What the *Plan Administrator* must do:

1. Provide initial general COBRA notices as required by law;

2. Determine if the *covered person* is eligible to continue coverage according to applicable laws;

3. Notify persons of the unavailability of COBRA continuation;

4. Notify the *covered person* of the *covered person's* rights to continue coverage provided that all required notice and notification procedures have been followed by the *covered employee*, covered spouse and/or covered dependent children;

5. Inform the *covered person* of the premium *contribution* required to continue coverage and how to pay the premium *contribution*; and

6. Notify the *covered person* when the *covered person* is no longer entitled to COBRA or when the *covered person's* COBRA continuation is ending before expiration of the maximum (18, 29, 36 month) continuation period.

What *You* must do:

1. *You* must notify the *Plan Administrator* in writing of a divorce or legal separation within 60 calendar days after either the date of the qualifying event, or the earliest date coverage would end due to the qualifying event, whichever is later;

2. *You* must notify the *Plan Administrator* in writing of a covered dependent child ceasing to be eligible within 60 calendar days after either the date of the qualifying event, or the earliest date coverage would end due to the qualifying event, whichever is later;

3. *You* must submit *your* written notice of a qualifying event within the 60-day timeframe, as explained previously in paragraphs 1 and 2, using the *Plan's* approved notice form. (*You* may obtain a copy of the approved form from the *Plan Administrator*.) This notice must be submitted to the *Plan Administrator* in writing and must include the following:
   - The name of the *Plan*;
   - The name and address of the *covered employee* or former *covered employee*;
   - The names and addresses of all applicable dependents;
   - The description and date of the qualifying event;
   - Requested documentation pertaining to the qualifying event such as: decree of divorce or legal separation; and
   - The name, address and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, dependent, or a representative acting on behalf of the employee or dependent.

All written notices as described previously in paragraphs 1, 2, and 3, under "What *You* must do" must be timely sent to the *Plan Administrator* at the address indicated in the section of this *SPD* entitled "Specific Information About *Your Plan*."

You must follow the *Plan's* procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this *SPD*, unless a different procedure is expressly required by the Employer or its COBRA administrator.

4. To elect continuation, *you* must notify the *Plan Administrator* of *your* election in writing within 60 calendar days after the date the *covered person's* coverage ends, or the date the *covered person* is notified of continuation rights, whichever is later. To elect continuation, *you* must complete and submit *your* written election within the 60-day timeframe using the *Plan's* approved election form. (*You* may obtain a copy of the approved form from the *Plan*

Administrator.) This election must be submitted to the *Plan Administrator* in writing at the address as described in this section; and

5. *You* must pay continuation premium *contributions*:
   a. The premium *contribution* to continue coverage is the combined Employer plus *covered employee* rate charged under the *Plan*, plus the Employer may charge an additional two percent of that rate. For a *covered person* receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months may be increased to 150% of the *Plan's* total cost of coverage. The continuation election form will set forth *your* continuation premium *contribution* rate(s).
   b. The first premium *contribution* must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the *covered person's* monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
   c. The *covered person* must pay subsequent premium *contributions* by check on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Plan*.

What *You* must do to apply for COBRA extension:

A. Social Security Disability:

1. If *you* are currently enrolled in COBRA continuation under this *Plan*, and it is determined that *you* are totally disabled by the Social Security Administration within the first 60 calendar days of *your* current COBRA coverage, then *you* may request an extension of coverage provided that *your* current COBRA coverage resulted from the *covered employee's* leave of absence, retirement, reduction in hours, layoff, or the *covered employee's* termination of employment for reasons other than gross misconduct. To request an extension of COBRA, *you* must notify the *Plan Administrator* in writing of the Social Security Administration's determination within 60 calendar days after the latest of:
   - The date of the Social Security Administration's disability determination;
   - The date of the *covered employee's* termination of employment, reduction of hours, leave of absence, retirement, or layoff; or
   - The date on which *you* would lose coverage under the *Plan* as a result of the *covered employee's* termination, reduction of hours, leave of absence, retirement, or layoff.

2. *You* must submit *your* written notice of total disability within the 60-day timeframe, as described previously in paragraph 1, and before the end of the 18th month of *your* initial COBRA coverage using the *Plan's* approved disability notice form. (*You* may obtain a copy of the approved form from the *Plan Administrator*.) This notice must be submitted, in writing, to the *Plan Administrator* and must include the following:
   - The name of the *Plan*;
   - The name and address of the *covered employee* or former *covered employee*;
   - The names and addresses of all applicable dependents currently on COBRA;
   - The description and date of the initial qualifying event that started *your* COBRA coverage;
   - The name of the disabled *covered person*;
   - The date the *covered person* became disabled;
   - The date the Social Security Administration made its determination of disability;
   - Requested copy of the Social Security Administration's determination of disability; and
   - The name, address and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, dependent, or a representative acting on behalf of the employee or dependent.

   You must follow the *Plan's* procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this *SPD*, unless a different procedure is expressly required by the Employer or its COBRA administrator.

   All written notices required for COBRA for a Social Security disability extension must be timely sent to the *Plan Administrator* at the address indicated in the section of this *SPD* entitled "Specific Information About *Your Plan*."

3. To elect an extension of COBRA, *you* must notify the *Plan Administrator* of the Social Security Administration's determination, in writing, within the 60 calendar day and the initial 18-month continuation period timeframes, by following the notification procedure as previously explained in paragraphs 1 and 2, and submitting the *Plan's* approved form; and

4. *You* must pay continuation premium *contributions*:
   a. The premium *contribution* to continue coverage is the combined Employer plus *covered employee* rate charged under the *Plan*, plus the Employer may charge an additional two percent of that rate. For a *covered person* receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months may be increased to 150% of the *Plan's* total cost of coverage. The disability notice form will set forth *your* continuation premium *contribution* rate(s).
   b. The first premium *contribution* must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the *covered person's* monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
   c. The *covered person* must pay subsequent premium *contributions* by check on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Plan*.

B. Second Qualifying Events for *Covered Dependent*s Only:

1. If *you* are currently enrolled in COBRA continuation under this *Plan* and the *covered employee* dies, or in the case of divorce or a legal separation of the *covered employee*, or a covered dependent child loses eligibility, then *you* may request an extension of coverage provided that *your* current COBRA coverage resulted from the *covered employee's* leave of absence, retirement, reduction in hours, layoff, or the *covered employee's* termination of employment for reasons other than gross misconduct or resulted from a Social Security Administration disability determination. To request an extension of COBRA, *you* must notify the *Plan Administrator* in writing within 60 calendar days after the later of:
   - The date of the second qualifying event (death, divorce, legal separation, loss of dependent child status); or
   - The date on which the *covered dependent*(s) would lose coverage as a result of the second qualifying event.

   Note: This extension is only available to a covered spouse and covered dependent children. This extension is not available when a *covered employee* becomes entitled to Medicare.

2. *You* must submit *your* written notice of a second qualifying event within the 60-day timeframe, as previously described in paragraph 1, using the *Plan's* approved second event notice form. (*You* may obtain a copy of the approved form from the *Plan Administrator*.) This notice must be submitted to the *Plan Administrator* in writing and must include the following:
   - The name of the *Plan*;
   - The name and address of the *covered employee* or former *covered employee*;
   - The names and addresses of all applicable dependents currently on COBRA;
   - The description and date of the initial qualifying event that started *your* COBRA coverage;
   - The description and date of the second qualifying event;
   - Requested documentation pertaining to the second qualifying event such as: a decree of divorce or legal separation or death certificate; and
   - The name, address and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, dependent, or a representative acting on behalf of the employee or dependent.

   You must follow the *Plan's* procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this *SPD*, unless a different procedure is expressly required by the Employer or its COBRA administrator.

   All written notices required for COBRA for a second qualifying event extension must be timely sent to the *Plan Administrator* at the address indicated in the section of this *SPD* entitled "Specific Information About *Your Plan*."

3. To elect an extension of COBRA, *you* must notify the *Plan Administrator* of the second qualifying event in writing within the 60 calendar day timeframe, by following the notification procedure as previously explained in paragraphs 1 and 2, and submitting the *Plan's* approved form; and

4. *You* must pay continuation premium *contributions*:

a. The premium *contribution* to continue coverage is the combined Employer plus *covered employee* rate charged under the *Plan*, plus the Employer may charge an additional two percent of that rate. For a *covered person* receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months may be increased to 150% of the *Plan's* total cost of coverage. The election form will set forth *your* continuation premium *contribution* rates.
b. The first premium *contribution* must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the *covered person's* monthly payments are due and payable by check at the beginning of each month for which coverage is continued.
c. The *covered person* must pay subsequent premium *contributions* by check on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Plan*.

Additional Notices *You* Must Provide: Other Coverages, Medicare Entitlement and Cessation of Disability

You must also provide written notice of (1) *your* other group coverage that begins after COBRA is elected under the *Plan*; (2) *your* Medicare entitlement (Part A, Part B or both parts) that begins after COBRA is elected under the *Plan*; and (3) the *covered person*, whose disability resulted in a COBRA extension due to disability, being determined to be no longer disabled by the Social Security Administration.

Your written notice for the events previously described in this section must be submitted using the *Plan's* approved notification form within 30 calendar days of the events requiring additional notices as previously described**. The notification form can be obtained from the *Plan Administrator* and must be completed by *you* and timely submitted** to the Plan Administrator at the address indicated in the section of this SPD entitled "Specific Information About Your Plan." In addition to providing all required information requested on the *Plan's* approved notification form, *your* written notice must also include the following:

- If providing notification of other coverage that began after COBRA was elected, the name of the *covered person* who obtained other coverage, and the date that other coverage became effective.
- If providing notification of Medicare entitlement, the name and address of the *covered person* that became entitled to Medicare and the date of the Medicare entitlement.
- If providing notification of cessation of disability, the name and address of the formerly disabled *covered person*, the date that the Social Security Administration determined that the *covered person* was no longer disabled and a copy of the Social Security Administration's determination.

If *you* do not provide this required additional notice, *you* must reimburse any claims mistakenly paid for expenses *incurred* after the following applicable date:

1. *Your* other group coverage begins;
2. *Your* Medicare Part A or Part B enrollment begins; or
3. *Your* disability ends.

CONTINUATION CHART

If coverage under this *Plan* is lost because this happens…	**Who is eligible to continue…**	**Coverage may be continued until the earliest of**: a) the date coverage would otherwise end under the *Plan*; or b) the end of the month in which the earliest of the following applicable events occurs:
The *covered employee's* leave of absence, early retirement, hours were reduced, layoff, or the *covered employee's* employment with the Employer ended for reasons other than gross misconduct.	*Covered employee*, covered spouse, and covered dependent children	• 18 months after continuation coverage began. • Coverage begins under another group health plan after COBRA is elected under the *Plan*. • Entitlement, after COBRA is elected under the *Plan*, of the applicable *covered person* to either Part A or Part B or both Parts of Medicare.
Death of the *covered employee*. Divorce or legal separation from the *covered employee*. Entitlement of the *covered employee* to Medicare within 18 months before the *covered employee's* hours were reduced or termination of employment for reasons other than gross misconduct. *Covered person* must provide timely notice of such event in accordance with the *Plan's* notice procedures previously described for such events.	Covered spouse and covered dependent children	• 36 months after continuation coverage began. • 36 months after entitlement of *covered employee* to Medicare but only for an event which is the *covered employee's* Medicare entitlement within 18 months before the *covered employee's* hours were reduced or termination of employment. • Coverage begins under another group health plan after COBRA is elected under the *Plan*. • Entitlement, after COBRA is elected under the *Plan*, of the applicable *covered person* to either Part A or Part B or both Parts of Medicare.
Loss of eligibility by a covered dependent child. *Covered person* must provide timely notice of such event in accordance with the *Plan's* notice procedures previously described for such events.	Covered dependent child	• 36 months after continuation coverage began. • Coverage begins under another group health plan after COBRA is elected under the *Plan*. • Entitlement, after COBRA is elected under the *Plan*, of the applicable *covered person* to either Part A or Part B or both Parts of Medicare.
The Employer files a voluntary or involuntary petition for protection under the bankruptcy laws found in Title XI of the United States Code.	Covered retiree, covered spouse, and covered dependent children	• Lifetime continuation coverage for covered retiree. • 36 months after death of covered retiree for covered spouse and covered dependent children. • Coverage begins under another group health plan after COBRA is elected under the *Plan*.
The *covered employee*, covered spouse or covered dependent child is determined by the Social Security Administration to be totally disabled within the first 60 calendar days of COBRA continuation coverage that resulted from the *covered employee's* leave of absence, early retirement, reduction in hours, layoff, or the *covered employee's* termination of employment with the Employer for reasons other than gross misconduct. Timely notice of such disability must be provided by the *covered person* in accordance with the *Plan's* notice procedures previously described for COBRA extensions due to Social Security disability.	*Covered employee*, covered spouse, and covered dependent children	• 29 months after continuation coverage began or until the first month that begins more than 30 calendar days after the date of any final determination that *covered employee*, covered spouse, or covered dependent child is no longer disabled. • Coverage begins under another group health plan after COBRA is elected under the *Plan*. • Entitlement, after COBRA is elected under the *Plan*, of the applicable *covered person* to either Part A or Part B or both Parts of Medicare.

Special Enrollment Periods

If *you* are a *covered employee*, covered spouse, or *covered dependent* who is enrolled in continuation coverage under this *Plan* due to a qualifying event (and not due to another enrollment event such as a special or annual enrollment), the Special Enrollment Period provisions of this *SPD* as referenced in the section which describes eligibility and enrollment will apply to *you* during the continuation period required by federal law as such provisions would apply to an active eligible *covered employee*. Eligible dependents that are newborn children or newly adopted children (as described in the eligibility and enrollment section) that are acquired by a *covered employee* during such *covered employee's* continuation period required by federal law and are enrolled through special enrollment, are entitled to continue coverage for the maximum continuation period required by law.

If the continuation period required by federal law has been exhausted, and *you* are enrolled for additional continuation coverage pursuant to state law, if applicable, or the eligibility provisions of this plan, *you* may be entitled to the special enrollment rights upon acquisition of a new dependent through marriage, birth, adoption, placement for adoption, or legal guardianship, as referenced in the section entitled Special Enrollment Period for *Covered Persons* due to the Acquisition of New Dependents.

Special Rule for Persons Qualifying for Federal Trade Act Adjustments

Federal trade act laws give special COBRA rights to *covered employees* who terminate employment or experience a reduction of hours, and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under federal laws, including the Trade Adjustment Assistance Reauthorization Act of 2015.

If *you* qualify or may qualify for trade adjustment assistance, contact the *Plan Administrator* for additional information. *You* must contact the *Plan Administrator* promptly after qualifying for trade adjustment assistance or *you* will lose your special COBRA rights.

Written Notices Required for COBRA Continuation

All notices, elections and information required to be furnished or submitted by a *covered person*, covered spouse, or covered dependent children for purposes of COBRA continuation must be submitted in writing by U.S. mail or hand-delivery, or as previously described in this section. Oral communications, including phone calls, voice mails or in-person statements and electronic e-mail do not constitute written notice and are not acceptable for COBRA purposes under the *Plan*.

XI. Subrogation and Reimbursement

Subrogation

The *Plan* and the *Plan Administrator* have the full and unrestricted right of subrogation with respect to any *sickness* or *injury* for which any *benefit* or payment is provided, or may at any time in the future be provided, under the *Plan*. The *Plan Administrator* has delegated to the *TPA* the ability to pursue this right, and the authority to redelegate such activity to other individuals or entities. That right of subrogation also extends to any coverage or rights a *covered person* has, or may have, under any insurance coverage, including, but not limited to, any uninsured or underinsured motorist coverage. The *Plan's* and the *Plan Administrator's* right of subrogation shall in all circumstances fully apply without limitation and shall not be reduced under any circumstances, even if a *covered person* is not made whole for damages or losses, such as damages for pain and suffering, lost wages, etc.

The *Plan's* and the *Plan Administrator's* subrogation rights shall also not be reduced by any expenses *incurred* by any *covered person*, including, but not limited to, attorneys' fees. Any and all amounts recovered by or on behalf of a *covered person* by settlement, judgment, arbitration or by any means whatsoever shall be placed into a constructive trust subject to the *Plan's* and the *Plan Administrator's* right of subrogation or shall be paid over to the *Plan* without any reduction, regardless of how such amounts are characterized or allocated. The *Plan's* and the *Plan Administrator's* subrogation rights shall have priority over any rights or claims of a *covered person*, and pursuant to such right of priority, the *Plan* shall first be paid in full for its subrogation rights before any amount, regardless of how characterized or allocated, is retained by, or for, a *covered person*.

A *covered person* shall fully cooperate with the *Plan*, the *Plan Administrator*, the *TPA* and their designees in the enforcement of the *Plan's* and the *Plan Administrator's* subrogation rights, which cooperation shall include, but not be limited to, paying over to the *Plan* any and all amounts due the *Plan* and the execution of any agreements, assignments or other instruments requested by the *Plan*, the *Plan Administrator*, the *TPA* and their designees. If

information and assistance are not provided to the *Plan* upon request, no *benefits* will be payable under the *Plan* with respect to costs *incurred* in connection with such *sickness* or *injury*. If the *sickness* or *injury* giving rise to subrogation involves a minor child or wrongful death of a *covered person*, this provision applies to the parents or guardian of the minor *covered person* and the personal representative of the deceased *covered person*. A *covered person* shall take no action which directly or indirectly adversely affects the *Plan's* and the *Plan Administrator's* rights of subrogation, and any settlement entered into by or on behalf of a *covered person* shall be subject to and shall fully recognize the *Plan's* and the *Plan Administrator's* right of priority to be fully repaid for its subrogation rights from any and all amounts, regardless of how characterized or allocated, recovered in connection with such settlement before any amounts from such settlement are retained by, or for, a *covered person*.

As a condition of receiving *benefits* under this *Plan*, *you* agree:

- To reimburse the *Plan* for any such *benefits* paid or payable to, or on behalf of, the *covered person* when said *benefits* are recovered from any form, regardless of how classified or characterized, from any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, medical payment provision or other insurance policies or funds.
- The *Plan Administrator* retains all fiduciary responsibilities with respect to the *Plan*, has the exclusive, final, and binding discretionary authority to interpret and administer the *Plan*, resolve any ambiguities that exist and make all factual determinations, except to the extent the *Plan Administrator* has expressly delegated to other persons or entities one or more fiduciary responsibilities with respect to the *Plan*. The rights of subrogation and reimbursement shall bind the *covered person's* guardian(s), estate, executor, personal representative, and heir(s).

Reimbursement Rights

You agree to hold in constructive trust the proceeds of any settlement or judgment for the *Plan's* and the *Plan Administrator's* benefit under this Section. If *you* fail to reimburse the *Plan* out of any recovery or reimbursement received for all *benefits* paid or to be paid as a result of *your sickness* or *injury*, *you* will be liable for any and all expenses, whether fees or costs, associated with the *Plan's*, the *Plan Administrator's*, the *TPA's* and their designees' attempts to recover such money from *you*.

XII. Coordination of Benefits

As a *covered person*, *you* agree to permit the *Plan* to coordinate obligations under this *SPD* with payments under any other health benefit plans as specified below, which cover *you* as an employee or dependent. *You* also agree to provide any information or submit any claims to other health benefit plans necessary for this purpose. *You* agree to authorize billing to other health plans for purposes of coordination of benefits.

This *Plan* does not coordinate *your prescription drug benefits* under this *SPD* with any other health plan's *prescription drug* benefits.

Unless applicable law prevents disclosure of the information without the consent of the *covered person* or the *covered person's* representative, each *covered person* claiming *benefits* under this *Plan* must provide any fact needed to pay the claim. If the information cannot be disclosed without consent, the *Plan* will not pay *benefits* until the information is given.

A. APPLICATION: This Coordination of Benefits provision applies when *you* have health care coverage under more than one plan. "Plan" is defined below.

B. DEFINITIONS. These definitions only apply to the Coordination of Benefits provision:

Allowable Expenses Means a *health care service* or expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense.

Claim Determination Period Means a calendar year. However, it does not include any part of a year during which a person has no coverage under this *Plan*, or before the date this Coordination of Benefit provision or a similar provision takes effect.

Closed Panel Plan Means a plan that provides health benefits to persons primarily in the form of services through a panel of *providers* that have contracted with or are employed by the plan, and that limits or excludes benefits or services provided by other *providers*, except in cases of *emergency* or referral by a panel member.

Custodial Parent Means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

Dependent A *covered employee's* eligible dependent as described in the section "Eligibility, Enrollment, and *Effective Date*" who is enrolled under the *Plan*.

Plan Means any of the following that provides benefits or services for medical or dental care or treatment. However, if separate policies are used to provide coordinated coverage for members of any group, the separate policies are considered parts of the same plan and there is no Coordination of Benefits among these policies.

a. Group, blanket, franchise, closed panel or other forms of group or group type coverage (insured or uninsured);
b. *Hospital* indemnity benefits in excess of $200 per day;
c. Medical care components of group long-term care policies, such as *skilled care*;
d. A labor-management trustee plan or a union welfare plan;
e. An employer or multi-employer plan or employee benefit plan;
f. Medicare or other governmental benefits, as permitted by law;
g. Insurance required or provided by statute;
h. Medical benefits under group or individual automobile policies;
i. Individual or family insurance for *hospital* or medical treatment or expenses;
j. Closed panel or other individual coverage for *hospital* or medical treatment or expenses.

Plan does not include any:

a. Amounts of hospital indemnity insurance of $200 or less per day;
b. Benefits for non-medical components of group long-term care policies;
c. School accident-type coverages;
d. Medicare supplement policies;
e. Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage listed above is a separate plan. If a plan has two parts and Coordination of Benefits rules apply to one of the two, each of the parts is treated as a separate plan. The benefits provided by a plan include those that would have been provided if a claim had been duly made.

Primary Plan/Secondary Plan Means the order of benefit determination rules which determine whether this *Plan* is a "primary plan" or "secondary plan" when compared to the other plan covering the person.

When this *Plan* is primary, its *benefits* are determined before those of any other plan and without considering any other plan's benefits. When this *Plan* is secondary, its *benefits* are determined after those of another plan and may be reduced because of the primary plan's benefits.

C. ORDER OF BENEFIT DETERMINATION RULES: The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

A plan that does not contain a Coordination of Benefits provision that is consistent with this section is always primary. **Exception**: Group coverage designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the employer.

A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

This *Plan* will not pay more than it would have paid had it been the primary plan. This *Plan* determines its order of *benefits* by using the first of the following that applies:

1. **Nondependent/Dependent**: The plan that covers the person other than a dependent, for example as an employee, subscriber, or retiree is the primary plan; and the plan that covers the person as a dependent is the secondary plan.

   Exception: If the person is a Medicare beneficiary and federal law makes Medicare:
   a. Secondary to the plan covering the person as a dependent; and
   b. Primary to the plan covering the person as a nondependent (e.g., a retired employee); then the order is reversed, so the plan covering that person as a nondependent is secondary and the other plan is primary.

2. **Child Covered Under More Than One Plan**: The order of benefits when a child is covered by more than one plan is:
   a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the plan that covered either of the parents for a longer time is primary.
   b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms; then that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is the plan of the:
      - Custodial parent;
      - Spouse of the custodial parent;
      - Noncustodial parent; and then
      - Spouse of the noncustodial parent.
   d. For a child covered under more than one plan by persons who are not the parents of such child, the order of benefits shall be determined under paragraph 2.a of this section as if those persons were parents of such child.
   e. For a dependent child who has coverage under either or both parents' plans and who also has coverage as a dependent under a spouse's plan, the rule in paragraph 5 of this section applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in paragraph 2.a of this section to the dependent child's parent(s) and the dependent's spouse.

3. **Active/Inactive Employee**: The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan that covers the person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits. For example: coverage provided to a person as a retired worker and as a dependent of an actively working spouse will be determined under the rule in paragraph 1.

4. **Continuation Coverage**: If a person whose coverage is provided under a right of continuation provided by the federal or state law is also covered under another plan, then:
   a. The plan covering the person as an employee, *covered person*, subscriber, or retiree (or as a dependent of an employee, *covered person*, subscriber, or retiree) is the primary plan.
   b. The continuation coverage is the secondary plan.
   c. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits.

5. **Longer/Shorter Length of Coverage**: The plan that covered the person as an employee, dependent or retiree for a longer time is primary.

D. THE EFFECT ON THE *BENEFITS* OF THIS *PLAN*: When this *Plan* is secondary, it may reduce its *benefits* at the time of processing, so that the total benefits paid or provided by all plans for each claim are not more than 100% of total allowable expenses for such claim. The reduction in this *Plan's benefits* is equal to the difference between:

1. The *benefit* payments that this *Plan* would have paid had it been the primary plan; and
2. The *benefit* payments that this *Plan* actually paid or provided.

When the *benefits* of this *Plan* are reduced as described above, each *benefit* is reduced in proportion to any applicable limit, such as a visit limit under this *Plan*.

E. RIGHT TO RECEIVE AND RELEASE INFORMATION: Certain facts about health care coverage and services are needed to apply Coordination of Benefit rules and to determine *benefits* payable under this *Plan* and other plans. The *TPA* may get the facts it needs from or give them to any other organization or person for the purpose of applying these rules and determining *benefits* payable under this *Plan* and other plans covering the person claiming *benefits*. The *TPA* need not tell, or get the consent of, any person to do this. Each person claiming *benefits* under this *Plan* must give the *Plan* any facts it needs to apply those rules and determine *benefits* payable.

F. FACILITY OF PAYMENT: A payment made under another plan may have included an amount that should have been paid under this *Plan*. If it does, the *Plan* may pay that amount to the organization that made the payment. That amount will then be treated as though it was a *benefit* paid under this *Plan*. The *Plan* will not pay that amount again. The term "payment made" includes providing *benefits* in the form of services. In this case "payment made" means the reasonable cash value of the *benefits* provided in the form of services.

G. RIGHT OF RECOVERY: If the *Plan* paid more than it should have paid, it may recover the excess from one or more of the following:

1. The persons the *Plan* has paid or for whom it has paid; or
2. Any other person or organization that may be responsible for the *benefits* or services provided under this *Plan* to the *covered person*.

The "amount of payments made" includes the reasonable cash value of any *benefits* provided in the form of services.

H. COORDINATING WITH MEDICARE:

If a *provider* has accepted assignment of Medicare, this *Plan* determines allowable expenses based upon the amount allowed by Medicare. This *Plan's* allowable expenses for a *participating provider* is the lesser of (1) the amount that the *participating provider* has contractually agreed to accept as reimbursement in full for *covered services* or (2) the Medicare allowable amount. This *Plan's* allowable expenses for a *non-participating provider* is the lesser of (1) the *usual and customary amount* or (2) the Medicare allowable amount. This *Plan* pays the difference between what Medicare pays and the *Plan's* allowable expenses.

If *you* are eligible for Medicare Part A on the basis of ESRD but *you* defer Medicare entitlement beyond the 30-month coordination period, *we* will cover the ESRD-related *health care services* provided to *you* during the period of deferment immediately following the 30-month coordination period only to the extent *we* would cover such ESRD-related *health care services* had *you* not deferred Medicare entitlement beyond the 30-month coordination period (but *we* will not otherwise differentiate between *you* and other *members* with respect to coverage for non-ESRD-related *health care services*).

XIII. How to Submit a Bill if *You* Receive One for *Covered Services*

A. Bills from Participating Providers

When *you* present *your* identification card at the time of requesting services from *participating providers*, paperwork and submission of post-service *claims* relating to services will be handled for *you* by *your participating provider*. *You* may be asked by *your provider* to sign a form allowing *your provider* to submit *claims* on *your* behalf. If *you* receive an invoice or bill from *your provider* for services, simply return the bill or invoice to *your provider*, noting *your* enrollment in the *Plan*. *Your provider* will then submit the post-service *claim* under the *Plan* in accordance with the terms of its participation agreement. *Your claim* will be processed for payment according to the Employer's coverage guidelines. The *TPA* must receive *claims* within 365 calendar days after the date services were *incurred* or a longer time period, if any, specifically set forth in the *participating provider*'s agreement or the national network agreement, except in the absence of *your* legal capacity. *Claims* received after the deadline will be denied.

B. Bills from Non-Participating Providers

The process described in this section pertains only to medical services. For information regarding *prescription drug services*, please refer to Magellan Rx in Addendum A attached to this *SPD*.

***Claim* Submission**. *You* must submit a completed *claim* form in writing, together with an itemized bill for the services *incurred*, on the *claim* form provided and in accordance with the filing procedures for post-service *claims* outlined in the next section. The *TPA* must receive *claims* within 180 calendar days after the date services were *incurred*, except in the absence of *your* legal capacity. If the *Plan* is discontinued, the deadline for the receipt of *claims* is 180 calendar days. *Claims* received after the deadline will be denied. If *you* need *claim* forms, please contact Customer Service.

Payment of *Claims*. *Claims* for *benefits* will be paid promptly upon receipt of written proof of loss. *Benefits* which are payable periodically during a period of continuing loss will be paid on a periodic basis. All or any portion of any *benefits* provided by the *Plan* may be paid directly to the *provider* rendering the services. Payment will be made according to the Employer's coverage guidelines.

XIV. Initial *Benefit* Determinations of Post-Service *Claims*

Post-service *claims* are *claims* that are filed for payment of *benefits* under the *Plan* after medical care has been received and submitted in accordance with the post-service *claim* filing procedures for the *Plan*.

Filing Procedure for Post-Service *Claims*. To file a post-service *claim*, *you* or *your* attending *provider* must submit an itemized bill in writing and in accordance with the procedures and within the deadlines described in the section entitled "How to Submit a Bill if *You* Receive One for *Covered Services*." To be considered a properly filed post-service *claim* under the *Plan*, *your* completed *claim* form, together with an itemized bill and the essential data elements, must be submitted in writing to Customer Service at the mailing address noted inside the cover page to this *SPD*. *Your* post-service *claim* must include at least the following essential data elements:

- The identity of the *covered person* and *provider* of services;
- The date(s) of services;
- A specific medical diagnosis; and
- Specific treatment, *health care service*, or procedure codes for which *benefit*s or payment is requested.

An explanation of these essential data elements will be provided to *you*, upon request and free of charge, by calling Customer Service. If *you* or *your* attending *provider* have not submitted the post-service *claim* in accordance with these filing procedures, including a failure to submit all essential data elements, *your* post-service *claim* will be treated as incorrectly filed. Please note that the time periods for making an initial *benefit* determination begin when Customer Service receives a written post-service *claim* submitted in accordance with the *Plan's* filing procedures.

If *your* attending *provider* files a post-service *claim* on *your* behalf, the *provider* will be treated as *your* authorized representative under the *Plan* for purposes of such *claim* and associated appeals unless *you* provide the *TPA* with specific direction otherwise within three business days from the *Plan Administrator's* notification that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

A request or inquiry that is not made in accordance with the *Plan's claim* procedures will not be treated as a *claim* under the *Plan*.

Initial *Benefit* Determination. If *your* post-service *claim* is denied, the *TPA* will communicate such denial within 30 calendar days after receipt of a post-service *claim* submitted in accordance with the *Plan's* filing procedures. If the *TPA* does not have all information it needs to make an initial *benefit* determination, it may extend the time period for the initial *benefit* determination by 15 calendar days. The *TPA* will notify *you* of the extension within the initial 30 calendar day period. *You* will then have 45 calendar days, or longer time as granted to *you* in the extension notification, to provide the requested information. The *TPA* will notify *you* of its initial *benefit* determination within 15 calendar days after the earlier of the *TPA's* receipt of the requested information or the end of the time period specified for *you* to provide the requested information. If *you* do not provide the requested information within the time period specified, *your claim* will be denied. If *you* and *your* authorized representative then submit the requested information within 180 calendar days after the date services were *incurred* (except in the absence of *your* legal capacity), the *Plan Administrator* may, but is not required to, reconsider the submitted information, and will not consider information it receives more than 365 calendar days after the date *your* services were *incurred*.

The time period for the initial *benefit* determination may also be extended for 15 calendar days for circumstances beyond the *TPA's* control.

If *your* post-service *claim* is denied, notification will be provided to *you*. This notice will explain:

- Information sufficient to identify the *claim* involved and any information required by law.
- The reason for the denial;
- The part of the *Plan* on which it is based;
- Any additional material or information needed to make the *claim* acceptable and the reason it is necessary; and
- The procedure for requesting an appeal.

Note: Refer to the section entitled "*Claim* Appeals Process" for details on requesting an appeal or external review.

XV. *Claim* Appeals Process

Internal Appeals Process

The internal review process for an appeal of a *claim* that is wholly or partially denied and for a rescission (retroactive termination) of *your* coverage, as defined by the *Affordable Care Act*, is:

1. **Acute Care Services Appeals**

   If *your* request for pre-certification of acute care services is wholly or partially denied and *you* have not received such services or if *you* are currently receiving acute care services and the continuation of these services is wholly or partially denied, *you* or *your* authorized representative may submit an appeal of that denial within 180 calendar days after receiving notice that *your* request was denied. *Your* appeal can be submitted to the *TPA* in writing, by telephone, or electronically, along with any issues, comments, and additional information, as appropriate. The *TPA* will forward *your* appeal to the *Plan Administrator* for its decision.

   As quickly as *your* medical condition requires, but no later than 72 hours of receipt of *your* appeal by the *Plan Administrator*, *you* will receive notice of the *Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based, and the procedure for requesting an external review. This time period may be extended if *you* agree.

2. **Non-Acute Care Services Appeals**

   a. **First Appeal**. If *your* request for pre-certification of non-acute care services is wholly or partially denied and *you* have not received such non-acute care services or if *you* are currently receiving non-acute care services and a request for the continuation of these services is wholly or partially denied, *you* or *your* authorized representative may submit an appeal of that denial within 180 calendar days after receiving notice that *your* request is denied. *Your* appeal can be submitted to the *TPA* in writing, along with any issues, comments, and additional information, as appropriate.

      Within 15 calendar days after *your* written first appeal is received by the *TPA*, *you* will receive notice of the *TPA's* decision, including the specific reasons for it, references to the part of the *Plan* on which it is based, and the procedure for requesting a second appeal from the *Plan Administrator*. This time period may be extended if *you* agree subject to applicable law.

b. **Second Appeal**. Within 60 calendar days after receiving a notice that *your* first appeal was denied, *you* or *your* authorized representative may submit a second appeal. *Your* second appeal can be submitted to the *TPA* in writing, along with any issues, comments, and additional information, as appropriate. The *TPA* will forward *your* second appeal to the *Plan Administrator* for its decision.

Within 15 calendar days after *your* written second appeal is received by the *Plan Administrator*, *you* will receive notice of the *Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based, and the procedure for requesting an external review. This time period may be extended if *you* agree subject to applicable law.

3. **Concurrent Care *Claims***

If *your* concurrent care *claim* for *benefit*s is wholly or partially denied, *you* or *your* authorized representative may submit an appeal to the *TPA* on the same basis as described above. Acute concurrent care *claim* appeal requests should be submitted to the *TPA*, and will be processed, the same as acute care services appeals above. Non-acute concurrent care *claim* appeal requests should be submitted to the *TPA*, and will be processed, the same as non-acute care services appeals above.

4. **Post-Service Appeals**

a. **First Appeal**. If *your* post-service *claim* for *benefit*s is wholly or partially denied, *you* or *your* authorized representative may submit an appeal within 180 calendar days after receiving notice that *your claim* is denied. *Your* appeal can be submitted to the *TPA* in writing, along with any issues, comments, and additional information as appropriate.

Within 30 calendar days after *your* written first appeal is received by the *TPA*, *you* will receive notice of the *TPA's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based, and the procedure for requesting a second appeal from the *Plan Administrator*. This time period may be extended if *you* agree.

b. **Second Appeal**. Within 60 calendar days after receiving a notice that *your* first appeal was denied, *you* or *your* authorized representative may submit a second appeal. *Your* second appeal can be submitted to the *TPA* in writing along with any issues, comments, and additional information, as appropriate. The *TPA* will forward *your* second appeal to the *Plan Administrator* for its decision.

Within 30 calendar days after *your* written second appeal is received by the *Plan Administrator*, *you* will receive notice of the *Plan Administrator's* decision, including the specific reasons for it and references to the part of the *Plan* on which it is based. This time period may be extended if *you* agree.

5. **Access to Relevant Documents**

Upon request and free of charge, *you* have the right to reasonable access to and copies of all documents, records, and other information relevant to *your* appeal. If the *Plan Administrator* or the *TPA* generates, relies upon, or considers any new or additional evidence in connection with an appeal, or identifies any new or additional rationale for a denial in connection with an appeal, it will be provided to *you* so that *you* have a reasonable opportunity to respond. *You* have the right to present written evidence and testimony as part of the appeals process.

External Review Process

If *your* request or *claim* is wholly or partially denied, reduced, or terminated based on medical judgment, as defined in the *Affordable Care Act*, or if *your* coverage is rescinded (retroactively terminated), as defined by the *Affordable Care Act*, *you* may have a right to have such decision reviewed by an independent review organization that is not associated with the *TPA*, *Plan* or *Plan Administrator*. The decision of the independent review organization is binding except to the extent other remedies may be available to the *Plan*, any person, or any entity under state or federal law. The following sections relating to Standard External Review and Expedited External Review apply only to a request or *claim* that is wholly or partially denied, reduced, or terminated based on medical judgment, as defined in the *Affordable Care Act* or if *your* coverage is rescinded (retroactively terminated), as defined by the *Affordable Care Act*:

1. **Standard External Review**. *You* may request an external review of any pre-service request or post-service *claim* based on medical judgment if *you* have exhausted all appeals available to *you* under the internal appeals process. Any denial, reduction, or termination of, or failure to provide payment for, a *benefit* based on a determination that

you failed to meet the requirements for eligibility under the terms of the *Plan* is not eligible for external review. Within four months after receiving a notice informing *you* of *your* right to an external review by an independent review organization, *you* or *your* authorized representative may submit a written request for an external review with an independent review organization by sending it to the *TPA*. When *you* request an external review, *you* will be required to authorize release of any medical records that the independent review organization might need to review for the purpose of reaching a decision.

Within one business day after completion of a preliminary review, which may take up to five business days, to confirm whether *you* were enrolled properly in the *Plan* at the time the pre-service *claim* was requested or post-service *claim* was provided, the *TPA* will notify *you* that *your* request is:

a. Complete and eligible for external review; or
b. Not complete, and will indicate what additional information or materials are needed to make it complete; or
c. Not eligible for external review and the reasons for its ineligibility.

If *your* request is complete and eligible for external review, the *TPA* will notify *you* which independent review organization will conduct the external review. *You* will then receive more detailed information, including contact information for the independent review organization and the independent review process and timetable.

2. **Expedited External Review**. *You* may request an expedited external review if:

   a. *Your* request for pre-certification of acute care services is wholly or partially denied and *you* have not received such services, or *you* are currently receiving acute care services and the continuation of these services is wholly or partially denied, and the timeframe for completion of an expedited internal appeal would seriously jeopardize *your* life, health, or ability to regain maximum function. Nevertheless, *you* must have filed a request for an expedited internal appeal in order to request an expedited external review; or
   b. *You* exhausted the internal appeals process and *you* have a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize *your* life, health, or ability to regain maximum function; or
   c. *You* exhausted the internal appeals process for coverage that involves an admission, availability of care, continued stay or health care item or service for which *you* received *emergency* services but have not been discharged from a facility.

   When *you* request an external review, *you* will be required to authorize release of any medical records that the independent review organization might need to review for the purpose of reaching a decision. Immediately upon receipt of *your* request for an expedited external review, the *TPA* will make a determination and notify *you* that *your* request is:

   - Complete and eligible for external review; or
   - Not complete, and will indicate what information or materials are needed to make it complete; or
   - Not eligible for external review and the reasons for its ineligibility.

   If *your* request is complete and eligible for the external review process, the *TPA* will notify *you* which independent review organization will conduct the external review. *You* will then receive more detailed information, including contact information for the independent review organization and the independent review process and timetable.

XVI. If *You* Have a Complaint

If the complaint involves issues relating to quality of health care rendered by a *participating provider*, *you* should also attempt to discuss the quality of care issues with the *provider*. *You* may also direct any questions or complaints to Customer Service. When Customer Service is contacted, the representative will assist *you* in trying to resolve the complaint with the *provider* on an informal basis. The representative will also document the complaint. If these discussions are not satisfactory, *you* may submit a written complaint to the *Plan Administrator*. However, the *Plan* is not responsible for the quality of care rendered by a *participating provider*.

XVII. No Guarantee of Employment or Overall *Benefits*

The adoption and maintenance of this *Plan* does not guarantee or represent that the *Plan* will continue indefinitely with respect to any class of employees and shall not be deemed to be a contract of employment between the Employer and any *covered employee*. Nothing contained herein shall give any *covered employee* the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any *covered employee*, at any time, nor shall it give the Employer the right to require any *covered employee* to remain in its employ or to interfere with the *covered employee's* right to terminate employment at any time not inconsistent with any applicable employment contract. Nothing in this *Plan* shall be construed to extend *benefit*s for the lifetime of any *covered person* or to extend *benefits* beyond the date upon which they would otherwise end in accordance with the provisions of the *Plan* or any *benefit* description.

XVIII. Definitions of Terms Used

Activities of Daily Living — *Eating, toileting, transferring, bathing, dressing*, walking, and *continence*.

Acute Care Facility — A facility that provides care to a *covered person* who is in the acute phase of a *sickness* or *injury* and who will have a stay of less than 30 calendar days.

Affordable Care Act — The federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance and regulations issued under these acts.

Ancillary Services — Subject to changes made by the U.S. Department of Health and Human Services, *ancillary services* are, with respect to a *hospital* or ambulatory surgical center, which is a *participating provider*:

1. *health care services* related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a *physician* or non-*physician* practitioner, and *health care services* provided by assistant surgeons, hospitalists, and intensivists;
2. diagnostic services (including radiology and laboratory services); and
3. *health care services* provided by a *non-participating provider* if there is no *participating provider* who can furnish such *health care services* at such *hospital* or ambulatory surgical center.

Bariatric Surgery — Surgery and related services for the treatment of obesity.

Bathing — Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Benefits — The *health care services* covered under the *Plan* as approved by the *Plan Administrator* as *covered services*, as explained in this *SPD* and any amendments.

Biofeedback — The technique of making unconscious or involuntary bodily processes (such as heartbeat or brain waves) perceptible to the senses in order to manipulate them by conscious mental control.

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

Claim — A request for *benefits* made by a *covered person* or the *covered person's* authorized representative in accordance with the procedures described in this *SPD*. It includes pre-certification requests

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. A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The *clinical trial* must meet one of the following:

1. Federally-funded *clinical trial* in which the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   a. National Institutes of Health.
   b. Centers for Disease Control and Prevention.
   c. Agency for Health Care Research and Quality.
   d. Centers for Medicare & Medicaid Services.
   e. Cooperative group or center of any of the entities described in paragraphs a through d above or the Department of Defense or the Department of Veterans Affairs.
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g. If the clinical study or investigation is conducted by the Department of Veterans Affairs, Department of Defense, or the Department of Energy, has been reviewed and approved through a system of peer review that the Secretary of the Department of Health and Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and there has been an unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
2. A study or investigation conducted under an investigational new drug application reviewed by the FDA.
3. The study or investigation is a drug trial that is exempt from having an investigational new drug application.

Coinsurance

A portion of *eligible charges* from *non-participating providers* that is paid by *you*. *Your coinsurance* is a percentage of those *eligible charges* that are: 1) calculated at the time the *claim* is processed, 2) subject to the *usual and customary amount* or (3) the amount *you* must pay after satisfying *your deductible* for *emergency services* provided by a *non-participating provider*.

Combination Drug

A *prescription drug* in which two or more chemical entities are combined into one commercially available dosage form.

Compassionate Use

A method of providing experimental therapeutics prior to final FDA approval for use in humans. This procedure is used with very sick individuals who have no other treatment options. Often, case-by-case approval must be obtained from the FDA for *compassionate use* of a drug, device, or therapy.

Compounded Drugs

Customized medications prepared by a pharmacist from scratch using raw chemicals, powders, and devices according to a *physician's* specifications to meet *your* needs.

Confinement

An uninterrupted stay of 24 hours or more in a *hospital*, *skilled nursing facility*, rehabilitation facility, or *residential treatment facility*.

Continence

Ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

Continuing Care Patient

Continuing care patient means a *covered person* who is:

1. Undergoing a course of treatment for a *serious and complex condition* from a *participating provider*;
2. Undergoing a course of institutional or inpatient care from a *participating provider*;
3. Scheduled to undergo nonelective surgery from a *participating provider*, including receipt of postoperative care from such *participating provider* with respect to such a surgery;
4. Pregnant and undergoing a course of treatment for the pregnancy from *participating provider*; or
5. Or was determined to be terminally ill (i.e. *you* have received a medical prognosis that *your* life expectancy is 6 months or less) and is receiving treatment for such illness from *participating provider*.

Contribution

The payment *your* Employer requires to be paid on behalf of or for *covered persons* for the provision of *covered services*. *Your* Employer will inform *you* of *your* share of the *contribution*.

Copayment

The fixed amount of *eligible charges you* must pay to the *provider* for covered *health care services* received. The *copayment* may not exceed the charge billed for the covered *health care service*.

Cosmetic

Services, medications, and procedures that improve physical appearance but do not correct or improve a physiological function, or are not *medically necessary*.

Covered Dependent

A *covered employee's* eligible dependent as described in the section "Eligibility, Enrollment, and *Effective Date*" who is enrolled under the *Plan*.

Covered Employee

The person:

1. On whose behalf *contribution* is paid; and
2. Whose employment is the basis for membership; and
3. Who is enrolled under the *Plan*.

Covered Person

A *covered employee* or *covered dependent*.

Covered Services

Health care services that are provided by *your provider* or clinic and are covered by the *Plan*, subject to all of the terms, conditions, limitations, and exclusions of the *Plan*.

Custodial Care

Services to assist in *activities of daily living* and personal care that do not seek to cure or do not need to be provided or directed by a skilled medical professional, such as assistance in walking, *bathing,* and *eating*.

Day Treatment Services

Any professional or *health care services* at a *hospital* or licensed treatment facility for the treatment of mental and substance use disorders.

Deductible

The amount of *eligible charges* that each *covered person* must incur in a *plan year* for *health care services* from *non-participating providers* before the *Plan* will pay *benefits*.

Dentist

A licensed doctor of dental surgery or dental medicine, lawfully performing dental services in accordance with governmental licensing privileges and limitations.

Designated Convenience Care Center

A health care clinic whose primary purpose is to provide immediate treatment for the diagnosis of minor conditions.

Dressing

Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

Eating

Feeding oneself by getting food into the body from a receptacle, such as a plate, cup, or table, or by a feeding tube or intravenously.

Educational

A *health care service*:

1. Whose primary purpose is to provide training in the *activities of daily living*, instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities; or
2. That is provided to promote development beyond any level of function previously demonstrated, except in the case of a child with congenital, developmental, or medical conditions that have significantly delayed speech or motor development as long as progress is being made towards functional goals set by the attending *physician*.

Effective Date

The date *your* coverage under this *SPD* is effective, which depends on the date that *you* timely complete all applicable enrollment requirements imposed by the *Plan Administrator*.

Eligible Charges

A charge for *health care services*, subject to all of the terms, conditions, limitations, and exclusions of the *Plan* for which the *Plan* or *covered person* will pay.

Emergency (Also Emergency Medical Condition)

See definition of *emergency medical condition*.

Emergency Department of a Hospital

A *hospital* outpatient department that provides *emergency services*.

Emergency Medical Condition (Also Emergency)

A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity, (including severe pain,) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Emergency Services

1. With respect to an *emergency medical condition*:
   a) A medical screening examination that is within the capability of the *emergency department of a hospital* or of an *independent freestanding emergency department*, as applicable, including *ancillary services* routinely available to the emergency department, to evaluate such *emergency medical condition*; and
   b) Within the capabilities of the staff and facilities available at the *hospital* or the *independent freestanding emergency department*, as applicable, such further medical examination and treatment *to stabilize* the patient (regardless of the department of the *hospital* in which such further examination or treatment is furnished).

2. Inclusion of additional services:
   a) Unless each of the conditions described in subclause 2.b. are met, items and services:
      i. Which are *covered services*; and
      ii. That are furnished by a *non-participating provider* or non-participating emergency facility (regardless of the department of the *hospital* in which such items or services are furnished) after *you* are *stabilized* and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in clause 1 are furnished.
   b) Conditions. If *you* are *stabilized* and furnished additional items and services described in subclause 2 after such stabilization by a *provider* or facility described in subclause 2, the conditions are the following:
      i. Such *provider* or facility determines *you* are able to travel using nonmedical transportation or nonemergency medical transportation.
      ii. Such *provider* furnishing such additional items and services satisfies the notice and consent criteria required by federal law with respect to such items and services.
      iii. *You* are in a condition to receive the information provided in the notice and to provide informed consent, in accordance with applicable federal and state law.
      iv. Any other conditions required by law, such as conditions relating to coordinating care transitions to *participating providers* and facilities.

ERISA

The Employee Retirement Income Security Act of 1974 and the implementing regulations, as amended from time to time.

Essential Health Benefits — The categories of services that qualified health plans are required to cover, as defined, and required by the *Affordable Care Act*. The *benefits* covered by this *SPD* may include some *essential health benefits*, but this *SPD* is not and is not intended to be a qualified health plan and does not, and is not required to, cover all *essential health benefits*.

Fee Schedule — The amount that the *participating provider* has contractually agreed to accept as reimbursement in full for *covered services*. This amount may be less than the *provider's* usual charge for the *health care service*.

If *health care services* are delivered to *you* via telehealth and/or virtual visit by a distant site *participating provider* who is **not** a designated *participating provider* for *telemedicine*, the *Plan* will reimburse such *participating provider* on the same basis and using the same *fee schedule* as would apply if the *covered services* had been delivered in person by the distant site *participating provider*.

Formulary — A list, which may change from time to time, of preferential *prescription drugs* that is used by the *Plan*.

Gravie — Gravie Administrative Services, which is a *third party administrator* (*TPA*) providing administrative services to *your* Employer in connection with the operation of the *Plan*.

Habilitative Therapy — Therapy provided to develop initial functional levels of movement, strength, daily activity, or speech.

Health Care Service(s) — Medical or behavioral services including pharmaceuticals, devices, technologies, tests, treatments, therapies, supplies, procedures, hospitalizations, or *provider* visits.

Homebound — When *you* are unable to leave home without considerable effort due to a medical condition. Lack of transportation does not constitute *homebound* status.

Hospital — A facility that provides diagnostic, medical, therapeutic, and surgical services by or under the direction of *physician*s and with 24-hour registered nursing services. The *hospital* is not mainly a place for rest or *custodial care*, and is not a nursing home or similar facility.

Incurred — *Health care services* rendered to *you* shall be considered to have been *incurred* at the time or date the *health care service* was actually purchased or provided.

Independent Freestanding Emergency Department — A health care facility that:

1. is geographically separate and distinct and licensed separately from a *hospital* under applicable State law; and
2. provides any of the *emergency services* listed in section i. of the definition of *emergency services*.

Infertility — Inability to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:

1. One year, if *you* are a female under age 35 or a male of any age, or
2. Six months, if *you* are a female age 35 or older,

provided that *your infertility* is not related to voluntary sterilization or failed reversal of voluntary sterilization.

Injury — Bodily damage other than *sickness* including all related conditions and recurrent symptoms.

Investigative

As determined by the *Plan Administrator*, a drug, device or medical treatment or procedure is *investigative* if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The *Plan Administrator* will consider the following categories of reliable evidence, none of which shall be determinative by itself:

1. Whether there is a final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the FDA; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared to standard means of treatment or diagnosis; and
2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in any authoritative compendia as identified by the Medicare program such as, the National Comprehensive Cancer Network Drugs and Biologics Compendium, as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care *providers* in the applicable specialty as determined by a sampling of *providers*, including whether there are protocols used by the treating facility or another facility, studying the same drug, device, medical treatment, or procedure.

Medically Necessary

Any *health care services*, *preventive health care services*, and other preventive services that the *Plan Administrator*, in its discretion and on a case-by-case basis, determines are appropriate and necessary in terms of type, frequency, level, setting, and duration, for *your* diagnosis or condition; and the care must:

1. Be consistent with the medical standards and generally accepted practice parameters of *providers* in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue;
2. Help restore or maintain *your* health;
3. Prevent deterioration of *your* condition;
4. Prevent the reasonably likely onset of a health problem or detect an incipient problem.

Medically Necessary Leave of Absence

A Leave of Absence by a full-time student Dependent at a postsecondary educational institution that meets all of the following requirements:

1. Commences while such Dependent is suffering from an Illness or Injury.

2. Is *Medically Necessary*.

3. Causes such Dependent to lose student status for purposes of coverage under the terms of the Plan.

Michelle's Law

Michelle's Law prohibits termination of student dependents by a group health *plan* or a health insurance issuer that provides health insurance coverage in connection with a group health *plan*, from terminating coverage of a student dependent due to a qualifying *Medically Necessary Leave of Absence* from, or other change in enrollment at, a postsecondary education institution prior to the earlier of:

1. The date that is one year after the first day of the *Medically Necessary Leave of Absence*.
2. The date on which such coverage would otherwise terminate under the terms of the *Plan*.

Named Fiduciary

The person or organization that has the authority to control and manage the operation and administration of the *Plan*. The fiduciary has discretionary authority to determine eligibility for *benefits* or to construe the terms of the *Plan* and may delegate such discretion to other individuals or entities.

Non-Designated Transplant Network Provider

A transplant *provider* that is not contracted with or through the *TPA* to provide organ or bone marrow transplant or stem cell support and any related services and aftercare. A *non-designated transplant network provider* may be either a *participating provider* or a *non-participating provider*.

Non-Participating Provider

1. A *physician* or other health care *provider* who, when providing *health care services*, is acting within the scope of practice of that *provider's* license or certification under applicable State law; or
2. A facility, like a clinic or *hospital*;

That is not a *participating provider.*

Non-Participating Provider Benefits

Coverage for *health care services* provided by licensed *providers* other than *participating providers.*

With *non-participating provider benefits*, *you* are financially responsible for *deductible, coinsurance,* and any amount in excess of *usual and customary amount.*

Orthognathic Surgery

Surgical manipulation of the elements of the facial skeleton to restore the proper anatomic and functional relationship in patients with dentofacial skeletal anomalies.

Out-of-Network Rate

The term *'out-of-network rate'* means, with respect to *emergency services* provided by a *non-participating provider*:

1. Subject to clause (iii), the amount determined in accordance with any state law in effect in the state where such *emergency services* were provided;
2. Subject to clause (iii), if no such state law which would determine the amount under clause (i) is in effect:
   i. Subject to subclause 2(b), the amount agreed to by the *TPA* and the *non-participating provider*; or
   ii. If the *TPA* and the *non-participating provider* enter the independent dispute resolution (IDR) process under the No Surprises Act and do not agree on an amount before a certified IDR entity makes a determination on the amount to be paid to the *non-participating provider*, then the amount determined by the certified IDR entity; or
3. In the case the state has an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the state approves under such All-Payer Model Agreement for such *emergency services* provided by the *non-participating provider*.

Out-of-Pocket Limit

The maximum amount of money *you* must pay for *health care services* from *participating providers* before this *Plan* pays *your eligible charges* at 100%. If *you* reach *benefit*, day, or visit maximums, *you* are responsible for amounts that exceed the *out-of-pocket limit*. Expenses *you* pay for *copayments* will apply to the *out-of-pocket limit*.

Participating Provider

1. A physician or other health care provider who is acting within the scope of practice of that *provider*'s license or certification under applicable State law; or
2. A facility, like a *hospital* or clinic:

That is directly contracted to participate in the specific *TPA participating provider* network designated by Plan Administrator to provide benefits to covered persons enrolled in this *SPD*. The participating status of providers may change from time to time.

Participating providers may also be offered from other Preferred Provider Organizations that have contracted with *TPA*.

Physical Disability

A condition caused by a physical *injury* or congenital defect to one or more parts of *your* body that is expected to be ongoing for a continuous period of at least two years from the date the initial proof is supplied to the *Plan Administrator* and as a result *you* are incapable of self-sustaining employment and are dependent on the *covered employee* for a majority of financial support and maintenance. An illness by itself will not be considered a *physical disability* unless adequate separate proof is furnished to the *Plan Administrator* for the *Plan Administrator* to determine that a *physical disability* also exists as defined in the preceding sentence.

Physician

A licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), or Doctor of Chiropractic (D.C.).

Plan

The self-insured employee welfare benefit plan, as defined by *ERISA*, established by the *Plan Sponsor* for the benefit of *covered persons*.

Plan Administrator

The entity, as defined under Section (3)(16) of *ERISA*, that has the exclusive, final and binding discretionary authority to administer the *Plan*, to make factual determinations, to construe and interpret the terms of the *SPD*, *Plan*, and amendments (including ambiguous terms), and to interpret, review and determine the availability or denial of *benefits*. The *Plan Administrator* may delegate discretionary authority and may employ or contract with individuals or entities to perform day-to-day functions, such as processing claims and performing other *Plan*-connected administrative services.

Plan Sponsor

The entity that establishes and maintains the *Plan*, has the authority to amend and/or terminate the *Plan* and is responsible for providing funds for the payment of *benefits*.

Plan Year

The period following the *effective date* of the *Plan* and each subsequent 12-month period this *Plan* remains in force.

Prescription Drug

A drug approved by the FDA for use only as prescribed by a *provider* properly authorized to prescribe that drug

Preventive Health Care Services

The *covered services* that are listed and covered in this *SPD* as shown under the *Preventive Health Care Services* and/or Preventive Contraceptive Methods and Counseling for Women sections of the *Benefit* Schedule.

Provider

A health care professional, *physician*, clinic, or facility licensed, certified, or otherwise qualified under applicable state law to provide *health care services* to *you*.

Qualifying Payment Amount

The calculation for this amount is to be determined in accordance with the applicable federal regulation. Call Customer Service for further information.

Recognized Amount

With respect to an item or service furnished by a *non-participating provider,* except for non-participating air ambulance services:

1. Subject to clause (iii), in the case of such item or service furnished in a state that has in effect a law that determines the amount to be paid for such item or service;
2. Subject to clause (iii), in the case of such item or service furnished in a state that does not have in effect such a state law, the amount that is the *qualifying payment amount*; or
3. In the case of such item or service furnished in a state with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the state approves under such system for such item or service.

Reconstructive

Medically necessary surgery to restore or correct:

1. A defective body part when such defect is incidental to or resulting from *injury*, *sickness*, or prior surgery of the involved body part; or
2. A covered dependent child's congenital disease or anomaly which has resulted in a functional defect as determined by a *physician*.

Rehabilitative Care

Skilled restorative service that is rendered for the purpose of maintaining and improving functional abilities, within a predictable period of time, (generally within a period of six months) to meet *your* maximum potential ability to perform functional daily living activities. Not considered *rehabilitative care* are: *skilled nursing facility* care; home health services; chiropractic services, speech, physical and occupational therapy services for chronic medical conditions, or long-term disabilities, where progress toward such functional ability maintenance and improvement is not anticipated.

Residential Treatment Facility

A facility that is licensed by the appropriate state agency and provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, or treatment for sickness related to mental health and substance use related disorders.

Routine Patient Costs

The cost of any *covered services* that would typically be covered if *you* were not enrolled in an approved *clinical trial. Routine patient costs* do not include:

1. The cost of the investigational item, device, or *health care service* that is the subject of the approved *clinical trial*.
2. Items and *health care services* provided solely to satisfy data collection and analysis needs and not used in direct clinical management.
3. A *health care service* that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Serious and Complex Condition	*Serious and complex condition* means, with respect to a *covered person*: 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; or 2. In the case of a chronic illness or condition, a condition that: i. Is life-threatening, degenerative, potentially disabling, or congenital; and ii. Requires specialized medical care over a prolonged period of time.
Sickness	Presence of a physical or mental illness or disease.
Skilled Care	Nursing or rehabilitation services requiring the skills of technical or professional medical personnel to provide care or assess *your* changing condition. Long-term dependence on respiratory support equipment does not in and of itself define a need for *skilled care*.
Skilled Nursing Facility	A Medicare licensed bed or facility (including an extended care facility, a long-term acute care facility, a *hospital* swing-bed, and a transitional care unit) that provides *skilled care*.
Specialist	*Providers* other than those practicing in the areas of family practice, general practice, internal medicine, OB/GYN or pediatrics.
Specialty Drugs	Injectable and non-injectable *prescription drugs,* as determined by the *Plan Administrator*, which have one or more of the following key characteristics: 1. Frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes; 2. Intensive patient training and compliance assistance are required to facilitate therapeutic goals; 3. There is limited or exclusive product availability and/or distribution; 4. There are specialized product handling and/or administration requirements; or 5. Are produced by living organisms or their products.
Stabilize, To	With respect to an *emergency medical condition*, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an *emergency condition* involving a pregnant woman who is having contractions, to deliver (including the placenta).
Summary Plan Description (SPD)	The document describing, among other things, the *benefits* offered under the Gravie Comfort $4,000 OOPM Medical Option of the *Plan* and *your* rights and obligations under such *benefit* option as required by *ERISA*.
Third Party Administrator (TPA)	*Gravie* provides administrative services to the Employer in connection with the operation of the *Plan*, including processing of claims, as may be delegated to it.
Telemedicine	Care provided by designated *participating providers* performed without physical face to face interaction, but through electronic (including telephonic) communication allowing evaluation, assessment and the management of *health care services* that leads to a treatment plan provided by a *participating provider* who is a licensed *physician* or a *participating provider* who is a qualified licensed health care professional. A list of *telemedicine participating providers* may be obtained by calling Customer Service or by checking the *Gravie* website at https://member.gravie.com. For purposes of this *SPD*, a *participating provider* who contracts to be a designated *telemedicine care participating provider* shall not be treated or construed as performing telehealth and/or virtual visit at a distant site.
Toileting	Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring	Moving into or out of a bed, chair, or wheelchair.
Transplant Services	Transplantation (including retransplants) of the human organs or tissue, including all related post-surgical treatment and drugs and multiple transplants for related care.
Urgent Care Center	A health care facility whose primary purpose is to offer and provide immediate, short-term medical care for minor immediate medical conditions not on a regular or routine basis.

Usual and Customary Amount	The average amount for each *covered service* or supply that by discretion of the *Plan Administrator* is customary in the geographic area in which the *health care service* is provided.
Vocational Rehabilitation	*Health care services* for a *covered person* designed to obtain or regain skills or abilities beyond those *activities of daily living*, including but not limited to, a device or an enhanced device or service requested or needed to enable the *covered person* to perform activities for an occupation.
Waiting Period	The period of time that an individual must wait before being eligible for coverage under the *Plan.*
You/Your/Yourself	Refers to *covered employee*, *covered dependent* or *covered person*.

XIX. Specific Information About *Your Plan*

The federal government requires that the following information be furnished for the Gravie Comfort $4,000 OOPM Medical Option of the *Plan*:

Name of the *Plan*:	This *Plan* shall be known as Celarity Group Health Plan. This SPD replaces, in full, the previously issued Gravie Medical Option SPD. This *SPD* is effective December 1, 2023.
Address of the *Plan*:	Celarity 8120 Penn Ave S Bloomington, MN 55431
Type of *Plan*:	Welfare Benefit Plan providing group health benefits
Group Number, as assigned by the *TPA*:	FHMQL
Employer Identification Number:	41-1790178
IRS *Plan* Identification Number:	501
***Plan* Year:**	December 01 through November 30
***Third Party Administrator* or *TPA*:** The company that provides certain administrative services in connection with the *Plan*. *TPA* shall not be deemed an employer with respect to the administration of or provision of *benefits* under *Plan Sponsor's Plan*.	Gravie Administrative Services P.O. Box 211543 Eagan, MN 55121
***Plan Sponsor* and Sponsor's Address:**	Celarity 8120 Penn Ave S Bloomington, MN 55431
***Plan Administrator* and Administrator's Address:** *Plan Administrator* retains all fiduciary responsibilities with respect to the *Plan*, except to the extent it has delegated one or more such responsibilities to others.	Benefits Committee Celarity 8120 Penn Ave S Bloomington, MN 55431
***Named Fiduciary*:**	Celarity 8120 Penn Ave S Bloomington, MN 55431
***Participating Provider*:**	Aetna network
Agent for Service of Legal Process:	Attention: Human Resource Department Celarity 8120 Penn Ave S Bloomington, MN 55431
Funding:	This is a level-funded plan, not insured by the *TPA* or an insurance carrier; the Employer provides funds from its general assets to pay *claims* under the *Plan*.
***Contributions* and Other Cost Sharing:**	The Employer and the employee share the cost of coverage. This cost sharing involves *contributions*, *deductibles*, *copayments,* and *coinsurance*. *Your* Employer funds and provides contributions for the cost of coverage and will inform *you* of *your* share of the *contribution*, which will be used to reimburse the Employer for the cost of coverage it provided. *Your* share of *deductibles*, *copayment* and *coinsurance* are described elsewhere in this *SPD*.

Addendum A

Magellan Rx

Prescription Drug Appeals

Plan Sponsor delegates to Magellan Rx (MRx) the authority to perform administrative and/or clinical initial *prescription drug* coverage determinations and appeals (whether first level, second level or urgent) filed by or on behalf of *covered persons*. In the event MRx issues a denial in connection with the final level of internal (*Plan*) appeal, MRx will, on *Plan Sponsor's* behalf, provide the *covered person* access to a panel of Independent Review Organizations (IROs) for the purpose of obtaining an external review if desired. MRx may offer the services of different IROs, or otherwise change the composition of the panel, during the term of the Agreement. MRx offers access to such IROs as a convenience to *Plan Sponsor*, and *Plan Sponsor* at all times retains the responsibility and authority to determine the IROs that will perform external reviews for the *Plan*.

Magellan Rx Contact Information:

Website:	www.magellanrx.com
Telephone:	1.800.424.0472
Address:	15950 N 76th Street
	Scottsdale, AZ 85260