PREFERRED PROVIDER

PLAN OF BENEFITS

Dear Member:

Blue Cross and Blue Shield of Kansas City (BCBSKC) is pleased to provide administrative services for your Group Health Plan as outlined in this Preferred Provider Plan of Benefits. BCBSKC provides you and your covered family members with cost-effective health care coverage administration both locally and on a nationwide basis.

Please refer to the Benefits outlined in this Plan of Benefits for all your health care coverage.

See your ID Card for specific phone numbers, including but not limited to:

- Customer Service
- Preauthorization
- Mental Health and Substance Use Disorder

TTY users please call:

- 800-735-8583

The Blue Cross and Blue Shield networks offer the best geographic access to Providers and Hospitals of any Preferred Provider Organization (PPO) in the nation. This national coverage is available through the BlueCard® Program in which all Blue Cross Plans participate. For more Provider information visit our website at https://www.MyHealthToolkitKC.com/.

We welcome you to our family of health care coverage through BCBSKC and look forward to meeting your health care administration needs.

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE

Under this Plan of Benefits, the Benefits you receive will depend on whether the Provider of medical services is a Participating or Non-Participating Provider. You will receive the maximum Benefits that can be paid if you use Participating Providers and you get Preauthorization, when required, before getting medical care. The amount you have to pay may increase when you do not use Participating Providers and if you do not get Preauthorization.

Members of the Blue Cross and Blue Shield Association (BCBSA) attempt to contract with Providers that practice at participating Hospitals. For various reasons, some Providers may elect not to contract as Participating Providers. If you use a Non-Participating Provider, you may have no protection from balance billing from the Provider, except where prohibited by applicable law.

BCBSKC (hereafter referred to as Corporation) is the claims administrator for this Preferred Provider Plan. BCBSKC has retained BlueCross BlueShield of South Carolina as a primary provider of claims processing, customer service, medical management, and other services.

HOW TO GET HELP

How to get help on Preauthorization:

For Magnetic Resonance Imaging (MRIs), Magnetic Resonance Angiography (MRAs), Computerized Axial Tomography (CAT) scans or Positron Emission Tomography (PET) scans in an outpatient facility:

- 866-500-7664

For all other medical care:

- 888-376-6544

Please do not call the above number(s) for claims inquiries.

Please note that Preauthorization is required for certain procedures. Please contact your Provider for additional information.

HOW TO FILE CLAIMS

Participating Providers have agreed to file claims for healthcare services they rendered to you. However, in the event a Provider does not file a claim for such services, it is your responsibility to file the claim. If you choose to use a Non-Participating Provider, you are responsible for filing your claim.

Once the claim has been processed, you will have quick access to an Explanation of Benefits (EOB) through our website or by contacting customer service. The EOB explains who provided the care, the kind of service or supply received, the amount billed, the Allowable Charge, the Coinsurance rate and the amount paid. It also shows Benefit Year Deductible information and the reasons for denying or reducing a claim.

The only time you must pay a Participating Provider is when you have a Benefit Year Deductible, Coinsurance, Copayment or when you have services or supplies that are not Covered Expenses under your Plan of Benefits.

If you need a claim form, you may obtain one from us at the address below or print a copy from the website. You can also call us at the number listed or website on your Identification Card and we will send you a form. After filling out the claim form, send it to the address below:

BlueCross BlueShield
P.O. Box 100121
Columbia, South Carolina 29202

Please refer to Article VIII of this Plan of Benefits for more information on filing a claim.

SCHEDULE OF BENEFITS

Employer Contract Number: 71-5944M-02 and appropriate subgroups
Employer: News-Press & Gazette Company
HDHP Plan
Plan of Benefits Effective Date: January 1, 2025

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of the Plan of Benefits. In the event of a conflict between the Plan of Benefits and this Schedule of Benefits, the Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in the Plan of Benefits.

To maximize your Benefits, seek medical services from a Participating Provider who participates in the Preferred Provider Organization (PPO). Please call 800-340-0109 if you are residing or traveling in the Kansas City area or 800-810-2583 if you are residing or traveling outside the Kansas City area or access our website at https://www.MyHealthToolkitKC.com/ **to find out if your Provider is a Participating Provider.**

GENERAL PROVISIONS **When a Benefit is listed below and has a dollar or percentage amount associated with it then the Benefit will be provided to Members subject to the terms of this Plan of Benefits. When a Benefit has a "Covered" notation associated with it, the Benefit will pay based on the location of the service (e.g. inpatient, outpatient, office). When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to the Member. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.**	
Benefit Year Deductible:	$6,600 per family with no one Member meeting more than $3,300 for Participating Providers (includes Non-Participating Providers of air ambulance services, Emergency Services, and non-Emergency Services furnished at certain Participating Provider facilities). $6,600 per family with no one Member meeting more than $3,300 for Non-Participating Providers. Covered Expenses that are applied to the Benefit Year Deductible shall contribute to both the Participating and Non-Participating Provider Benefit Year Deductibles.

Out-of-Pocket Maximums:	$8,000 per family with no one Member meeting more than $4,000 for Participating Providers (includes Non-Participating Providers of air ambulance services, Emergency Services, and non-Emergency Services furnished at certain Participating Provider facilities). $16,000 per family with no one Member meeting more than $8,000 for Non-Participating Providers. Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. If Coinsurance does not contribute to the Out-of-Pocket Maximum, the percentage of reimbursement does not change from the amount indicated on the Schedule of Benefits. Coinsurance, Benefit Year Deductibles and Copayments which apply to the Out-of-Pocket Maximum shall contribute to both the Participating and Non-Participating Provider Out-of-Pocket Maximums.

This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Year. The Anniversary Date is 01/01.

PREAUTHORIZATION

Any questions about Preauthorization should be directed to either your Provider or to the Corporation at the number on the back of your Identification Card.

Preauthorization is required for the following services:

- All facility Admissions for non-emergent medical and behavioral health services
- Applied Behavioral Analysis (ABA) related to Autism Spectrum Disorder
- Ambulance services (non-emergency)
- Cleft lip and palate
- Dental care for accidental injury (Preauthorization is required for the treatment plan and subsequent visits)
- Rental of Durable Medical Equipment
- Purchase of Durable Medical Equipment over $500
- Home Health Care
- Hospice Care
- Interdisciplinary pain management program
- Orthopedic devices
- Orthotic devices
- Outpatient Services
    - Any surgical procedure that may be potentially cosmetic: i.e., blepharoplasty, reduction mammoplasty
    - Cancer chemotherapy (initial notification)
    - Hysterectomy
    - Investigational procedures
    - Radiation therapy (initial notification)
    - Sclerotherapy
    - Septoplasty
- Oxygen
- Radiology management<
    - CAT scan
    - MRI
    - MRA
    - PET scan

Please refer to the Corporation’s website for a complete list of Specialty Drugs that require Preauthorization.

The penalties for not obtaining preauthorization, when required, are as follows:

Denial of room and board charges:

- All facility Admissions for non-emergent medical and behavioral health services

Denial of all charges:

- ABA related to Autism Spectrum Disorder
- DME purchase of $500 or more
- Home Health Care
- Hospice Care (see facility Admissions for inpatient Hospice Care by a Participating Provider)
- Radiology management
- Outpatient services

Reduction of Benefits:

- Psychological testing performed in the office, reduced by 50% of the Allowable Charge
- rTMS performed in the office, reduced by 50% of the Allowable Charge

ADMISSIONS/INPATIENT BENEFITS The below include services for medical, mental health and substance use disorders			
	Participating Provider	**Non-Participating Provider at a Participating Provider facility** **(unless the Provider satisfies advance patient notice and consent requirements)**	**Non-Participating Provider at a Non-Participating Provider facility** **(or at a Participating Provider facility if advance patient notice and consent requirements are met)**
Inpatient Hospital charges during an Admission (non-emergency)	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hospital Admission resulting from an emergency room visit	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible	The Employer pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	**Non-Participating Provider**
Inpatient physical rehabilitation services	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Skilled Nursing Facility Admissions (limited to thirty (30) days per Member per Benefit Year) and Residential Treatment Center Admissions	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

OUTPATIENT BENEFITS
The below include services for medical, mental health and substance use disorders

	Participating Provider	**Non-Participating Provider at a Participating Provider facility** **(unless the Provider satisfies advance patient notice and consent requirements)**	**Non-Participating Provider at a Non-Participating Provider facility** **(or at a Participating Provider facility if advance patient notice and consent requirements are met)**
Outpatient Hospital services (non-emergency)	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	**Non-Participating Provider**
Lab, X-ray and other diagnostic services	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient emergency room services	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible

	Participating Provider	Non-Participating Provider
Urgent care	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Surgery	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	For certain surgeries performed by a Non-Participating Provider at certain Participating Provider facilities (unless the Provider satisfies advance patient notice and consent requirements): The Employer pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member generally pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible For all other surgeries: The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Maternity	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Rehabilitation related to physical therapy and occupational therapy All rehabilitation services related to physical therapy and occupational therapy are limited to a combined sixty (60) visits per Member per Benefit Year*	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation related to physical therapy and occupational therapy All habilitation services related to physical therapy and occupational therapy are limited to a combined sixty (60) visits per Member per Benefit Year*	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Rehabilitation related to speech therapy All rehabilitation services related to speech therapy and hearing therapy are limited to a combined twenty (20) visits per Member per Benefit Year*	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation related to speech therapy Habilitative speech therapy (other than approved ABA therapy for Autism Spectrum Disorder) is limited to Members age six (6) and younger All habilitation services related to speech therapy are limited to a combined twenty (20) visits per Member per Benefit Year*	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

*Physical therapy, speech therapy and occupational therapy Benefits have no visit limits for Members with Autism Spectrum Disorder, Mental Health or Substance Use diagnosis.

PROVIDER SERVICES The below include services for medical, mental health and substance use disorders			
	Participating Provider	**Non-Participating Provider at a Participating Provider facility** **(unless the Provider satisfies advance patient notice and consent requirements)**	**Non-Participating Provider at a Non-Participating Provider facility** **(or at a Participating Provider facility if advance patient notice and consent requirements are met)**
Inpatient Provider Services for an Admission resulting from an emergency room visit	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Inpatient Provider Services (non-emergency)	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	For certain Inpatient Provider Services performed by a Non-Participating Provider at certain Participating Provider facilities (unless the Provider satisfies advance patient notice and consent requirements): The Employer pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member generally pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible For all other Inpatient Provider Services: The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Surgical Services, when rendered in a Hospital, Provider's office or Ambulatory Surgical Center (non-emergency)	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	For certain Surgical Services performed by a Non-Participating Provider at certain Participating Provider facilities (unless the Provider satisfies advance patient notice and consent requirements): The Employer pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member generally pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible For all other Surgical Services: The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Provider Services for lab, X-ray and other diagnostic services	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for lab, X-ray and other diagnostic services performed at an independent laboratory facility	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Provider Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	For certain Provider Services performed by a Non-Participating Provider at certain Participating Provider facilities (unless the Provider satisfies advance patient notice and consent requirements): The Employer pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member generally pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible For all other Provider Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center: The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for an outpatient emergency room visit	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible
Provider Services for rehabilitation related to physical therapy and occupational therapy All rehabilitation services related to physical therapy and occupational therapy are limited to a combined sixty (60) visits per Member per Benefit Year*	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Provider Services for habilitation related to physical therapy and occupational therapy All habilitation services related to physical therapy and occupational therapy are limited to a combined sixty (60) visits per Member per Benefit Year*	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for rehabilitation related to speech therapy All rehabilitation services related to speech therapy and hearing therapy are limited to a combined twenty (20) visits per Member per Benefit Year*	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for habilitation related to speech therapy Habilitative speech therapy (other than approved ABA therapy for Autism Spectrum Disorder) is limited to Members age six (6) and younger All habilitation services related to speech therapy are limited to a combined twenty (20) visits per Member per Benefit Year*	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider's Services in the office, including contraceptives and birth control devices** (excluding physical therapy, speech therapy and occupational therapy)	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Rehabilitation in a Provider’s office related to physical therapy and occupational therapy All rehabilitation services related to physical therapy and occupational therapy are limited to a combined sixty (60) visits per Member per Benefit Year*	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Habilitation in a Provider's office related to physical therapy and occupational therapy All habilitation services related to physical therapy and occupational therapy are limited to a combined sixty (60) visits per Member per Benefit Year*	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Rehabilitation in a Provider's office related to speech therapy All rehabilitation services related to speech therapy and hearing therapy are limited to a combined twenty (20) visits per Member per Benefit Year*	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation in a Provider's office related to speech therapy Habilitative speech therapy (other than approved ABA therapy for Autism Spectrum Disorder) is limited to Members age six (6) and younger All habilitation services related to speech therapy are limited to a combined twenty (20) visits per Member per Benefit Year*	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Teladoc general office visit	The Employer pays 100% of the Allowable Charge after the Benefit Year Deductible	Non-Covered
Teladoc Behavioral Health Services by a Psychiatrist - Initial Visit	The Employer pays 100% of the Allowable Charge after the Benefit Year Deductible	Non-Covered
Teladoc Behavioral Health Services by a Psychiatrist - Ongoing Visits	The Employer pays 100% of the Allowable Charge after the Benefit Year Deductible	Non-Covered
Teladoc Behavioral Health Services by a licensed therapist other than a Psychiatrist	The Employer pays 100% of the Allowable Charge after the Benefit Year Deductible	Non-Covered

	Participating Provider	Non-Participating Provider
Teladoc dermatology visit	The Employer pays 100% of the Allowable Charge after the Benefit Year Deductible	Non-Covered

*Physical therapy, speech therapy and occupational therapy Benefits have no visit limits for Members with Autism Spectrum Disorder, Mental Health or Substance Use diagnosis.
**Contraceptives and birth control devices covered under the Affordable Care Act (ACA) will pay at 100% of the Allowable Charge at Participating Providers. No Benefits are payable at Non-Participating Providers.

OTHER SERVICES			
	Blue Distinction® Center or Blue Distinction® Center+	**Participating Provider**	**Non-Participating Provider**
Human organ and tissue transplant services Provider charges are subject to the Benefit Year Deductible	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	**Non-Participating Provider**
Travel and lodging for covered human organ and tissue transplant services for donors, recipients and their family members, limited to $10,000 per Member per transplant Expenses for travel and lodging are not associated with any network. Therefore, any expenses which meet the criteria for coverage will be paid at the payment level provided	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	
Air ambulance service	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible
Ground ambulance service	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Durable Medical Equipment, Prosthetics and Orthopedic Devices, including Transcutaneous Electrical Nerve Stimulation (TENS) units	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Diabetic shoes, limited to one (1) pair of diabetic shoes and three (3) pair of inserts per Member per Benefit Year	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Formula and food products for phenylketonuria	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Cochlear implants	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Medical Supplies	Covered	Covered
Home Health Care, limited to sixty (60) visits per Member per Benefit Year	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Hospice Care, limited to fourteen (14) days per Member per episode	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
ABA related to Autism Spectrum Disorder, limited to Members diagnosed at age nineteen (19) or younger	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Acupuncture	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Chiropractic services	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Infertility treatment, limited to a maximum of $5,000 per Member per lifetime*	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Temporomandibular Joint Disorder (TMJ) including treatment	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Orthognathic surgery	Covered	Covered
Dental anesthesia and outpatient facility charges related to dental are limited to the following: • Members age five (5) and under; • Members who are severely disabled; or • Members with a medical or behavioral condition requiring hospitalization or general anesthesia when dental care is provided by a physician, Certified Registered Nurse Anesthetist (CRNA) or dentist in a Hospital, surgical center or office	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Gender affirming Surgical Services	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Cardiac therapy	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Pulmonary therapy	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
First pair of eyeglasses or non-disposable contact lenses or refractive keratoplasty, only following cataract surgery, and for eye exams including refraction, as a result of a covered medical illness or an accidental injury	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Orthoptic training for the treatment of convergence insufficiency, for Members under the age of eighteen (18) years, limited to twelve (12) visits per Member per lifetime	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Penile implant following treatment for cancer**	The Employer pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

*Benefits are limited to $5,000 per Member per lifetime, not combined with infertility Prescription Drugs and sexual dysfunction Prescription Drugs.
**Covered services for penile implants will not count towards the lifetime maximum for impotency under the pharmacy Benefits.

PREVENTIVE BENEFITS The Benefit Year Deductible does not apply to these Benefits		
	Participating Provider	**Non-Participating Provider**
Preventive Benefits under the Affordable Care Act (ACA) (Refer to www.healthcare.gov for guidelines)	Covered	Non-Covered

SUSTAINED HEALTH SERVICES This Benefit does not include preventive Benefits offered under the Affordable Care Act (ACA). Payment will be made for the ACA preventive Benefits prior to Sustained Health services. See the preventive Benefits section in this Schedule of Benefits for payment of preventive Benefits under the ACA.		
	Participating Provider	**Non-Participating Provider**
Pap smear screenings for routine and diagnostic pap test (the report and interpretation only), limited to one (1) per Member per Benefit Year	The Employer pays 100% of the Allowable Charge	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Physical exam, including well women exams, limited to one (1) per Member per Benefit Year	The Employer pays 100% of the Allowable Charge	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Prostate screenings for routine and diagnostic tests, limited to one (1) per Member per Benefit Year	The Employer pays 100% of the Allowable Charge	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Well Child Care performed in the Provider's office, including immunizations, for dependents	The Employer pays 100% of the Allowable Charge	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Immunizations	The Employer pays 100% of the Allowable Charge	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Flu shots, including Flu Mist	The Employer pays 100% of the Allowable Charge	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Routine bone density screenings	The Employer pays 100% of the Allowable Charge	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Routine and diagnostic colonoscopies, including all related services	The Employer pays 100% of the Allowable Charge	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Routine and diagnostic mammography screenings for any female Member age forty (40) or older	The Employer pays 100% of the Allowable Charge	The Employer pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

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ARTICLE I - DEFINITIONS

Capitalized terms that are used in this Plan of Benefits shall have the following defined meanings:

ACA: the Affordable Care Act of 2010, as amended.

Accountable Care Organization (ACO): a group of healthcare Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their Member populations.

Administrative Expense Allowance (AEA) Fee: the AEA Fee is a fixed per-claim dollar amount charged by the Host Blue to Corporation for administrative services the Host Blue provides in processing claims for Employer's Members. The dollar amount is normally based on the type of claim (e.g. institutional, professional, international, etc.) and can also be based on the size of your group enrollment. The amount of the AEA Fee is listed on the Schedule A.

Admission: the period of time between a Member's admission as a patient into a Hospital or Skilled Nursing Facility and the time the Member leaves or is discharged.

Adverse Benefit Determination: any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Group Health Plan, and including, a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which Benefits are otherwise provided because it is determined to be Investigational or Experimental or not Medically Necessary or appropriate. An Adverse Benefit Determination includes any cancellation or discontinuance of coverage that has retroactive effect (whether or not there is an adverse effect on any particular Benefit), except to the extent attributable to a failure to pay any required premiums or Employee contributions.

Allowable Charge: the amount the Corporation or a licensee of the BCBSA agrees to pay a Provider as payment in full for a service, procedure, supply or equipment. Additionally:

1. The Allowable Charge shall not exceed the Maximum Payment, unless otherwise required by applicable law;

2. The Allowable Charge for Emergency Services (including air ambulance services) provided by Non-Participating Providers, as well as non-Emergency Services provided by Non-Participating Providers at Participating Hospitals, Hospital outpatient departments, Critical Access Hospitals, or Ambulatory Surgical Centers, will pay in accordance with applicable federal law; and,

3. In addition to the Member's liability for Benefit Year Deductibles, Copayments and/or Coinsurance, the Member may be balance billed by the Non-Participating Provider for any difference between the Allowable Charge and the Billed Charge, except where prohibited by applicable law.

   For covered items and services described in item 2, above, the Allowable Charge will be the Recognized Amount (less any applicable Benefit Year Deductible, Copayment and/or Coinsurance), unless otherwise prescribed under applicable law. If the Provider disputes such Allowable Charge and initiates a 30-day open negotiation and/or independent dispute resolution process in accordance with applicable federal law, the Corporation will administer such processes.

Notwithstanding anything herein to the contrary, the Member's responsibility for Benefit Year Deductibles, Copayments and/or Coinsurance for covered items and services provided by Non-Participating Providers described in item 2, above, will be calculated as if the item or service was furnished by a Participating Provider, and based on the Recognized Amount (which may differ from the Allowable Charge).

Alternate Recipient: any child who is recognized under a Medical Child Support Order as having a right to enroll in this Plan of Benefits.

Ambulatory Surgical Center: a licensed facility that:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;

2. Provides treatment by or under the supervision of licensed medical doctors or oral surgeons and provides nursing services when the Member is in the facility;

3. Does not provide inpatient accommodations; and,

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a licensed medical doctor or oral surgeon.

An Ambulatory Surgical Center includes any licensed facility described in section 1833(i)(1)(A) of the Social Security Act.

Applied Behavioral Analysis (ABA): behavioral modification to target cognition, language and social skills for Autism Spectrum Disorder.

Authorized Representative: an individual (including a Provider) whom the Member designates in writing to act on such Member's behalf.

Autism Spectrum Disorder: the diagnoses designated as such in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Behavioral Health Clinician: a Clinician who renders Mental Health Services and/or Substance Use Disorder Services and is licensed to practice independently.

Behavioral Health Services: all Mental Health Services and/or Substance Use Disorder Services performed by a licensed Behavioral Health Clinician.

Benefit Detail Report: the document (in electronic or hardcopy form) maintained by the Corporation which reflects the benefits selected by the Employer and submitted to the Corporation which outlines the Benefits to be offered under the Group Health Plan. The Corporation shall administer the Plan of Benefits in accordance with the terms of the Benefit Detail Report. In the event of any conflict between the Benefit Detail Report and this Plan of Benefits or the Schedule of Benefits, the Benefit Detail Report shall control.

Benefit Year: the period of time set forth on the Schedule of Benefits. The initial Benefit Year may be more or less than twelve (12) months.

Benefit Year Deductible: the amount, if any, listed on the Schedule of Benefits that must be paid by the Member each Benefit Year before the Group Health Plan will pay Covered Expenses. The Benefit Year Deductible is subtracted from the Allowable Charge before Coinsurance is calculated. Members must refer to the Schedule of Benefits to determine if the Benefit Year Deductible applies to the Out-of-Pocket Maximum.

Benefit(s): medical services or Medical Supplies that are:

1. Medically Necessary;

2. Preauthorized (when required under this Plan of Benefits or the Schedule of Benefits);

3. Included in Article II of this Plan of Benefits; and,

4. Not limited or excluded under the terms of this Plan of Benefits.

Billed Charges: the actual charges as billed by a Provider.

BlueCard Program: a program in which all members of the BCBSA participate. Details of the BlueCard Program are more fully set forth in Article IX.

Care Coordination: organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

Care Coordinator: an individual within a Provider organization who facilitates Care Coordination for patients.

Care Coordinator Fee: a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a VBP.

Claims Amount: the amount paid (or payable) for Members' claims (including fees such as Access Fees, AEA Fees and amounts paid as part of a VBP or in settlement of claims or in satisfaction of a judgement).

Clinical Trials: a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and meets any of the following criteria:

1. Approved or funded through the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS), or a cooperative group or center of:

    a. Any of the preceding entities;

    b. The Department of Defense (DOD); or

    c. The Department of Veteran Affairs (VA);

2. Approved or funded by the DOD, VA, or Department of Energy (DOE), provided that the study or investigation has been reviewed and approved through a peer review system that the Secretary of the agency determines to be comparable to the peer review system of studies and investigations used by the NIH, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

3. Approved or funded through a qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or,

4. Either conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA), or a drug trial that is exempt from having such an investigational new drug application.

COBRA: those provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended, which require certain Employers to offer continuation of healthcare coverage to Employees and dependents of Employees who would otherwise lose coverage.

COBRA Administrator: the Corporation or its designated subcontractor that provides administrative services related to COBRA.

Coinsurance: the sharing of the Allowable Charge between the Member and the Group Health Plan. After the Member's Benefit Year Deductible requirement is met, the Group Health Plan will pay the percentage of Allowable Charges as set forth on the Schedule of Benefits. The Member is responsible for the remaining percentage of the Allowable Charge. Coinsurance is calculated after any applicable Benefit Year Deductible or Copayment is subtracted from the Allowable Charge based upon the network charge or the lesser charge of the Provider.

Companion Benefit Alternatives (CBA): a separate company that is responsible for managing Behavioral Healthcare Services (including Preauthorization) on behalf of BCBSKC.

Concurrent Care Claim: any claim for an ongoing course of treatment to be provided over a period of time or number of treatments.

Congenital Disorder/Congenital Disease: a condition documented as existing at birth regardless of cause.

Continuation of Care: the payment of Participating Provider level of Benefits for services rendered by certain Non-Participating Providers for a definite period of time in order to ensure continuity of care for covered Members for a Serious Medical Condition.

Continued Stay Review: the review that must be obtained by a Member (or the Member's Authorized Representative) regarding an extension of an Admission to determine if an Admission for longer than the time that was originally Preauthorized is Medically Necessary (when required). The Continued Stay Review process is outlined in Article II.

Continuing Care Patient: a Member who, with respect to a Provider or facility, is either:

1. Undergoing a course of treatment for a serious and complex condition from the Provider or facility;

2. Undergoing a course of institutional or inpatient care from the Provider or facility;

3. Scheduled to undergo nonelective surgery from the Provider or facility, including receipt of postoperative care;

4. Pregnant and undergoing a course of treatment for the pregnancy from the Provider or facility; or,

5. Receiving treatment for a terminal illness from the Provider or facility.

For this purpose, a serious and complex condition means a condition that, in the case of an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or in the case of a chronic illness or condition, is life-threatening, degenerative, potentially disability, or congenital and requires specialized medical care over a prolonged period of time.

Copayment: the amount, if any, specified on the Schedule of Benefits that the Member must pay directly to the Provider each time the Member receives Benefits.

Corporation: Blue Cross and Blue Shield of Kansas City (BCBSKC).

Covered Expenses: the amount payable by the Group Health Plan for Benefits. The amount of Covered Expenses payable for Benefits is determined as set forth in this Plan of Benefits and at the percentages set forth on the Schedule of Benefits. Covered Expenses are subject to the limitations and requirements set forth in the Plan of Benefits and on the Schedule of Benefits. Covered Expenses will not exceed the Allowable Charge.

Critical Access Hospital: a facility that is designated by the state in which it is located and certified by the United States Department of Health and Human Services as a critical access hospital.

Custodial Care: non-skilled services that are primarily for the purpose of assisting an individual with daily living activities or personal needs (e.g., bathing, dressing and/or eating), which is not specific therapy for any illness or injury.

Durable Medical Equipment (DME): medical equipment that:

1. Can withstand repeated use;
2. Is Medically Necessary;
3. Is customarily used for the treatment of a Member's illness, injury, disease or disorder;
4. Is appropriate for use in the home;
5. Is not useful to a Member in the absence of illness or injury;
6. Does not include appliances that are provided solely for the Member's comfort or convenience;
7. Is a standard, non-luxury item; and,
8. Is ordered by a licensed medical doctor, oral surgeon, podiatrist or osteopath.

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment.

Emergency Admission Review: the review that must be obtained by a Member (or the Member's Authorized Representative) within twenty-four (24) hours after or if later, by the end of the first working business day after the commencement of an Admission to a Hospital resulting from an Emergency Medical Condition. The Emergency Admission Review process is outlined in Article II.

Emergency Medical Condition: 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:

1. Placing the health of the Member, or with respect to a pregnant Member, the health of the Member or the Member's unborn child, in serious jeopardy;

2. Serious impairment to bodily functions; or,

3. Serious dysfunction of any bodily organ or part.

Emergency Services: an appropriate medical screening examination, services, supplies and treatment for stabilization, evaluation and/or initial treatment of an Emergency Medical Condition when provided on an outpatient basis at a Hospital emergency room or department or an independent freestanding emergency department, as well as post-stabilization services provided as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished.

Employee: any employee of the Employer who is eligible for coverage and who is so designated to the Corporation by the Employer.

Employer: the entity providing this Plan of Benefits.

Employer's Effective Date: the date the Corporation begins to provide Services under this Agreement.

ERISA: the Employee Retirement Income Security Act of 1974, as amended.

Global Payment/Total Cost of Care: a payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and Prescription Drugs.

Group Health Plan: the employee welfare benefit plan established, administered and/or sponsored by the Employer to provide health Benefits to Employees and/or their dependents, directly or through insurance, reimbursement or otherwise.

HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Agency: an agency or organization licensed by the appropriate state regulatory agency to provide Home Health Care.

Home Health Care: part-time or intermittent nursing care; health aide services; or physical, occupational or speech therapy provided or supervised by a Home Health Agency and provided to a home-bound Member in such Member's private residence.

Hospice Care: care for terminally ill patients under the supervision of a licensed medical doctor and provided by an agency that is licensed or certified as a hospice or hospice care agency by the appropriate state regulatory agency.

Hospice Services: services provided in the Member's home or in the home of a family member. Generally, Hospice Services are not available to Members who are inpatients in a Hospital or nursing home facility.

Hospice Services include:

1. Services provided by a registered nurse (RN) or licensed practical nurse (LPN);
2. Physical, speech and occupational therapy;
3. Services provided by a home health aide or medical social worker;
4. Nutritional guidance;
5. Diagnostic services;
6. Administration of Prescription Drugs;
7. Medical and surgical supplies;
8. Oxygen and its use;
9. Durable Medical Equipment; and,
10. Family counseling concerning the patient's terminal condition.

Hospital: a short-term, acute care facility licensed as a hospital by the state in which it operates. A Hospital is primarily engaged in providing medical, surgical or acute behavioral health diagnosis and treatment of injured or sick persons by or under the supervision of a staff of licensed Providers and continuous twenty-four (24) hour-a-day services by licensed, registered, graduate nurses physically present and on duty. The term Hospital does not include Long Term Acute Care Hospitals; chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Hospital. A Hospital may participate in a teaching program. This means medical students, interns or residents participating in a teaching program may treat Members.

Identification Card: the card issued by the Corporation to a Member that contains the Member's identification number.

Incapacitated Dependent: a child who is:

1. Incapable of financial self-sufficiency by reason of total disability; and,
2. Dependent upon the Employee for at least fifty-one (51) percent of the child's support and maintenance.

A child must meet both of these requirements to qualify as an Incapacitated Dependent. The Employee will provide proof upon request. A child who is not incapacitated by the maximum dependent child age will not be covered.

Investigational or Experimental: surgical or medical procedures, supplies, devices or drugs which, at the time provided or sought to be provided, are, in the judgment of the Corporation, not recognized as conforming to generally accepted medical or behavioral health practice in the United States, or the procedure, drug or device:

1. Has not received required final approval in the United States to market from appropriate government bodies;

2. Is one about which the peer-reviewed medical literature in the United States does not permit conclusions concerning its effect on health outcomes;

3. Is not demonstrated in the United States to be superior to established alternatives;

4. Has not been demonstrated in the United States to improve net health outcomes; or,

5. Is one in which the improvement claimed is not demonstrated in the United States to be obtainable outside the Investigational or Experimental setting.

Legal Intoxication/Legally Intoxicated: the Member's blood alcohol level was at or in excess of the amount established under applicable state law to create a presumption and/or inference that the Member was under the influence of alcohol when measured by law enforcement or medical personnel.

Long-Term Acute Care Hospital: a long-term, acute care facility licensed as a long term care Hospital by the state in which it operates and which meets the other requirements of this definition. A Long-Term Acute Care Hospital provides highly skilled nursing, therapy and medical treatment to Members (typically over an extended period of time) although such Members may no longer need general acute care typically provided in a Hospital. A Long-Term Acute Care Hospital is primarily engaged in providing diagnostic services and medical treatment to Members with chronic diseases or complex medical conditions. The term Long-Term Acute Care Hospital does not include chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a long-term acute care hospital. A Long-Term Acute Care Hospital may participate in a teaching program. This means medical students, interns or residents participating in a teaching program may treat Members.

Maximum Payment: the maximum amount the Group Health Plan will pay (as determined by the Corporation) for a particular Benefit. The Maximum Payment will not be affected by any credit. The Maximum Payment will be one of the following as determined by the Corporation in its discretion, subject to any different amount that may be required under applicable law:

1. The actual charge submitted to the Corporation for the service, procedure, supply or equipment by a Provider;

2. An amount based upon the reimbursement rates established by the Plan Sponsor in its Benefit Detail Report;

3. An amount that has been agreed upon in writing by a Provider and the Corporation or a licensee of the BCBSA;

4. An amount established by the Corporation, based upon factors including, but not limited to:

    a. Governmental reimbursement rates applicable to the service, procedure, supply or equipment; or,

b. Reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved; geographic location and circumstances giving rise to the need for the service, procedure, supply or equipment; or,

5. The lowest amount of reimbursement the Corporation allows for the same or similar service, procedure, supply or equipment when provided by a Participating Provider.

In addition, the Maximum Payment for Emergency Services or air ambulance services by a Non-Participating Provider, or non-Emergency Services by a Non-Participating Provider at a Participating Hospital, Hospital outpatient department, Critical Access Hospital, or Ambulatory Surgical Center, will be the Recognized Amount, unless a different Maximum Payment amount is permitted or required under applicable law.

Medical Child Support Order: any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency which:

1. Provides child support with respect to a child or provides for health benefit coverage to a child, is made pursuant to a state domestic relations law (including a community property law) and relates to the Plan of Benefits; or,

2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.

A Medical Child Support Order must clearly specify:

1. The name and the last known mailing address (if any) of each participant Employee and the name and mailing address of each Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Group Health Plan to each such Alternate Recipient or the manner in which such type of coverage is to be determined;

3. The period to which such order applies; and,

4. Each Group Health Plan to which such order applies.

If the Medical Child Support Order is a national medical support notice, the order must also include:

1. The name of the issuing agency;

2. The name and mailing address of an official or agency that has been substituted for the mailing address of any Alternate Recipient; and,

3. The identification of the underlying medical child support order.

A Medical Child Support Order meets the requirement of this definition only if such order does not require a Group Health Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993).

Medical Supplies: supplies that are:

1. Medically Necessary;

2. Prescribed by a Provider acting within the scope of such Provider's license;

3. Are not available on an over-the-counter basis (unless such supplies are provided to a Member in a Provider's office and should not be included as part of the treatment received by the Member); and,

4. Are not prescribed in connection with any treatment or Benefit that is excluded under this Plan of Benefits.

Medically Necessary/Medical Necessity: using United States standards health care services and/or Behavioral Health Services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical or behavioral health practice;

2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;

3. Not primarily for the convenience of the patient, patient's caregiver(s) or Provider; and,

4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

All requirements of the above-referenced definition must be met in order for a health care service or Behavioral Health Service to be deemed Medically Necessary. The failure of a health care service or Behavioral Health Service to meet any one of the above referenced requirements means, in the discretion of the Corporation or CBA, the health care service or Behavioral Health Service does not meet the definition of Medically Necessary.

For the purposes of determining Medical Necessity:

1. The Corporation and CBA have the discretion to utilize and rely upon any medical and behavioral health (which includes substance use and mental health) standards, policies, guidelines, criteria, protocols, manuals, publications, studies or literature (herein collectively referred to as "criteria"), whether developed by them or others, which, in their discretion, are determined to be generally accepted standards by the medical and/or behavioral health community;

2. "Generally accepted standards of medical or behavioral health practice" means United States standards that are based on credible scientific evidence published in peer-reviewed medical and/or behavioral health literature generally recognized by the relevant United States medical or behavioral health community, physician or behavioral health specialty society recommendations, and/or any other factors deemed relevant in the discretion of the Corporation or CBA; and,

3. The Corporation and CBA may, in their discretion, use the following materials, including but not limited to, Corporate Administrative Medical ("CAM") Policies, Technology Evaluation Center ("TEC") Assessments, Behavioral Health Care Utilization Management Criteria and/or any Care Guidelines or criteria by MCG Health, LLC, its affiliated companies, or other entities generally recognized as providing industry guidance and expertise, which reflect clinically appropriate health care services and Behavioral Health Services and generally accepted standards of medical and behavioral health practice. MCG Health, LLC, its affiliated companies, and/or other entities are independent companies that develop evidence based guidelines and criteria for medical, behavioral health and insurance industries to interpret clinical determinations and determine the Medical Necessity and appropriateness of requested services, procedures, devices and supplies.

Member: an Employee or dependent who has enrolled under the Group Health Plan.

Mental Health Services: treatment (except Substance Use Disorder Services) that is defined, described or classified as a psychiatric disorder or condition in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and which is not otherwise excluded by the terms and conditions of this Plan of Benefits.

Natural Teeth: teeth that:

1. Are free of active or chronic clinical decay;

2. Have at least fifty percent (50%) bony support;

3. Are functional in the arch; and,

4. Have not been excessively weakened by multiple dental procedures; or,

5. Teeth that have been treated for one (1) or more of the conditions referenced in 1-4 above and, as a result of such treatment, have been restored to normal function.

Negotiated Arrangement/Negotiated National Account Arrangement: an agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

Non-Participating Provider: any Provider who does not have a current, valid Provider Agreement.

Orthopedic Device: any ridged or semi-ridged leg, arm, back or neck brace and casting materials that are directly used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

Orthotic Device: any device used to mechanically assist, restrict or control function of a moving part of the Member's body.

Out-of-Pocket Maximum: the maximum amount (listed on the Schedule of Benefits) incurred during a Benefit Year that a Member will be required to pay for Covered Expenses.

Over-the-Counter Drug: a drug that does not require a prescription.

Participating Provider: a Provider who has a current, valid Provider Agreement.

Patient-Centered Medical Home (PCMH): a model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

Plan: any program that provides Benefits or services for medical or dental care or treatment, including:

1. Individual or group coverage, whether insured or self-insured; and,

2. Coverage under a governmental plan or coverage required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan for purposes of this Plan of Benefits. If a Plan has two (2) or more parts and the coordination of benefit rules in Article IV apply only to one (1) of the parts, each part is considered a separate Plan.

Plan Administrator: the entity charged with the administration of the Group Health Plan. The Employer is the Plan Administrator of the Group Health Plan.

Plan of Benefits: this document which reflects the Benefits offered under the Group Health Plan based on the Benefit Detail Report. The Plan of Benefits includes the Schedule of Benefits. Employer agrees that the Plan of Benefits will, at a minimum, be incorporated as a part of the Group Health Plan.

Plan of Benefits Effective Date: 12:01 a.m. EST on the date listed on the Schedule of Benefits.

Plan Sponsor: the party sponsoring the Group Health Plan. The Employer is the Plan Sponsor of the Group Health Plan.

Post-Service Claim: any claim for a Benefit that is not a Pre-Service Claim.

Preadmission Review: the review that must be obtained by a Member (or the Member's Authorized Representative) prior to all Admissions that are not related to an Emergency Medical Condition. The Preadmission Review process is outlined in Article II.

Preauthorized/Preauthorization: the approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member. The Preauthorization process is outlined in Article II.

Prescription Drug: a drug or medicine that is:

1. Required to be labeled that it has been approved by the FDA; and,

2. Bears the legend "Caution: Federal Law prohibits dispensing without a prescription" prior to being dispensed or delivered or labeled in a similar manner.

Additionally, to qualify as a Prescription Drug, the drug must be prescribed by a licensed Provider acting within the scope of such Provider's license.

Certain Over-the-Counter Drugs may be designated as Prescription Drugs.

Pre-Service Claim: any request for a Benefit where Preauthorization must be obtained before receiving the medical care, service or supply.

Primary Plan: a Plan whose Benefits must be determined without taking into consideration the existence of another Plan.

Private Duty Nursing (PDN): hourly or shift skilled nursing care provided in a patient's home. PDN provides more individual and continuous skilled care than can be provided in a skilled nurse visit through a Home Health Agency. The intent of PDN is to assist the patient with complex direct skilled nursing care, to develop caregiver competencies through training and education and to optimize patient health status and outcomes. The frequency and duration of PDN services is intermittent and temporary in nature and is not intended to be provided on a permanent ongoing basis. PDN is not long-term care.

Prosthetic Device: any device that replaces all or part of a missing body organ or body member, except a wig, hairpiece or any other artificial substitute for scalp hair.

Protected Health Information (PHI): has the same meaning as the term is defined under HIPAA.

Provider: any person or entity licensed by the appropriate state regulatory agency and legally entitled to practice within the scope of such person or entity's license in the practice of any of the following:

1. Medicine;
2. Dentistry;
3. Optometry;
4. Podiatry;
5. Chiropractic services;
6. Behavioral health;
7. Physical therapy;
8. Oral surgery;
9. Speech therapy;
10. Occupational therapy; or,
11. Osteopathy.

The term Provider also includes a Hospital; a Rehabilitation Facility; a Skilled Nursing Facility; a physician assistant; nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a licensed medical doctor or oral surgeon; and Behavioral Health Services when performed by a Behavioral Health Clinician, licensed professional counselor, masters level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Clinician approved by the Corporation. The term Provider does not include interns, residents, physical trainers, lay midwives or masseuses.

Provider Agreement: an agreement between the Corporation (or another BCBSA licensee) and a Provider under which the Provider has agreed to accept the Corporation's allowance (as set forth in the Provider Agreement) as payment in full for Benefits (subject to the member liability amounts) and other mutually acceptable terms and conditions.

Provider Incentive: an additional amount of compensation paid to a healthcare Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Provider Services: includes the following services:

A. When performed by a Provider or a Behavioral Health Clinician within the scope of such Provider or Clinician's license, training and specialty and within the scope of generally acceptable medical standards:

    1. Office visits, which are for the purpose of seeking or receiving care for a preventive service, illness or injury;

    2. Basic diagnostic services and machine tests; or,

    3. Behavioral Health Services.

B. When performed by a licensed medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, dentist, physical therapist, speech therapist, occupational therapist or licensed psychologist with a doctoral degree:

    1. Benefits rendered to a Member in a Hospital or Skilled Nursing Facility;

    2. Benefits rendered in a Member's home;

    3. Surgical Services;

    4. Anesthesia services, including the administration of general or spinal block anesthesia;

    5. Radiological examinations;

    6. Laboratory tests; and,

    7. Maternity services, including consultation; prenatal care; conditions directly related to pregnancy, delivery and postpartum care and delivery of one (1) or more infants. Provider Services also include maternity services performed by certified nurse midwives when supervised by a licensed medical doctor.

Qualified Medical Child Support Order: a Medical Child Support Order that:

    1. Creates or recognizes the existence of an Alternate Recipient's right to enroll under this Plan of Benefits; or,

    2. Assigns to an Alternate Recipient the right to enroll under this Plan of Benefits.

Qualifying Event: for continuation of coverage purposes under Article V, a Qualifying Event is any one (1) of the following:

1. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked;

2. Death of the Employee;

3. Divorce or legal separation of the Employee from such Employee's spouse;

4. A child ceasing to qualify as a dependent under this Plan of Benefits;

5. Entitlement to Medicare by an Employee or by a parent of a child; or,

6. A proceeding in bankruptcy under Title 11 of the United States Code with respect to an Employer from whose employment an Employee retired at any time.

Recognized Amount: the lesser of the Non-Participating Provider's Billed Charges or the Corporation's median contracted rate for Participating Providers for the same or similar item or service furnished in the same or similar specialty in the same geographic region; provided that, except in connection with air ambulance services, if there is a recognized amount specified for this purpose under an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act, or if not, under applicable state law, then such amount, as applicable, will instead serve as the Recognized Amount.

Rehabilitation Facility: licensed facility operated for the purpose of assisting Members with neurological or other physical injuries to recover as much restoration of function as possible.

Residential Treatment Center (RTC): a licensed and accredited institution, other than a Hospital, which meets all six (6) of these requirements:

1. Maintains permanent and full-time facilities for bed care of resident patients;

2. Has the services of a psychiatrist (addictionologist, when applicable) or physician extender available at all times and is responsible for the diagnostic evaluation and provides face-to-face evaluation services with documentation a minimum of once per week and PRN as indicated;

3. Has a physician or RN on full-time duty who is in charge of patient care along with one (1) or more RNs or LPNs on duty at all times (twenty-four (24) hours per day and seven (7) days per week);

4. Keeps a daily medical record for each patient;

5. Is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp or any other facility that provides Custodial Care; and,

6. Is operating lawfully as a residential treatment center in the area where it is located.

Schedule of Benefits: the pages of this Plan of Benefits, so titled, which specify the coverage provided and the applicable Copayments, Coinsurance, Benefit Year Deductibles, Out-of-Pocket Maximums and Benefit limitations.

Second Surgical Opinion: the medical opinion of a board-certified surgeon regarding an elective surgical procedure. The opinion must be based on the surgeon's examination of the patient. The examination must be performed after another licensed medical doctor has proposed to perform surgery, but before the surgery is performed. The second licensed medical doctor must not be associated with the primary licensed medical doctor.

Secondary Plan: a Plan that is not a Primary Plan. When this Plan of Benefits constitutes a Secondary Plan, availability of Benefits are determined after those of the other Plan and may be reduced because of benefits payable under the other Plan.

Serious Medical Condition: a health condition or illness that requires medical attention and for which failure to provide the current course of treatment through the current Provider would place the Member's health in serious jeopardy. This includes cancer, acute myocardial infarction and pregnancy.

Skilled Nursing Facility: a licensed and accredited institution, other than a Hospital, which meets all six (6) of these requirements:

1. Maintains permanent and full-time facilities for bed care of resident patients;

2. Has the services of a physician available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once per week and PRN as indicated;

3. Has a physician or RN on full-time duty who is in charge of patient care, along with one (1) or more RNs or LPNs on duty at all times (twenty-four (24) hours a day; seven (7) days a week);

4. Keeps a daily medical record for each patient;

5. Is primarily providing continuous skilled nursing care for sick or injured patients during the recovery stage of their illnesses or injuries and isn't, other than incidentally, a rest home or a home for Custodial Care for the aged; and,

6. Is operating lawfully as a skilled nursing facility in the area where it is located.

Special Care Unit: a specially equipped unit of a Hospital, set aside as a distinct care area, staffed and equipped to handle seriously ill Members requiring extraordinary care on a concentrated and continuous basis such as burn, intensive or coronary care units.

Specialist: a licensed medical doctor who specializes in a particular branch of medicine.

Specialty Drugs: Prescription Drugs, as identified by the Corporation, that treat a complex clinical condition and/or require special handling, such as refrigeration. They generally require complex clinical monitoring, training and expertise. Specialty Drugs include, but are not limited to, infusible Specialty Drugs for chronic diseases, injectable and self-injectable drugs for acute and chronic diseases and specialty oral drugs. Specialty Drugs are used to treat acute and chronic disease states (e.g., growth deficiencies, hemophilia, Multiple Sclerosis, Rheumatoid Arthritis, Gaucher's Disease, Hepatitis, cancer, organ transplantation, Alpha 1-Antitrypsin Disease and immune deficiencies).

Substance Use Disorder: the continued use of, abuse of and/or dependence on legal or illegal substance(s) despite significant consequences or marked problems associated with the use (as defined, described or classified in the most current version of *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association).

Substance Use Disorder Services: services or treatment relating to Substance Use Disorder.

Surgical Services: an operative or cutting procedure, including the usual, necessary and related pre-operative and post-operative care when performed by a licensed medical doctor.

Telehealth: the exchange of Member information during which Members can have a telephone or video consultation with a licensed health care professional.

Telemedicine: the exchange of Member information from one eligible referring licensed Provider (for purposes of Telemedicine outlined herein, the "Referring Provider") site to another eligible consulting licensed Provider (for purposes of Telemedicine outlined herein, the "Consulting Provider") site for the purpose of providing medical care to a Member in circumstances in which in person, face-to-face contact with the Consulting Provider is not necessary. The exchange must occur via two-way, real-time, interactive, HIPAA-compliant, electronic audio and video telecommunications systems.

Urgent Care Claim: any claim for medical care or treatment where making a determination under other than normal time frames could seriously jeopardize the Member's life or health or the Member's ability to regain maximum function, or, in the opinion of a licensed medical doctor or oral surgeon with knowledge of the Member's medical condition, would subject the Member to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

USERRA: the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Value-Based Program (VBP): a healthcare delivery model such as a patient-centered medical home ('PCMH'), accountable care organization ('ACO'), capitation arrangements or episode-based arrangements aimed at improving patient health quality and outcomes with respect to certain diseases and/or conditions. These services are facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment. The VBP is described further in this Agreement and the Plan of Benefits.

Value-Based Shared Savings: a payment mechanism in which the Provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

Well Baby Care/Well Child Care: care for dependents. Benefits are payable as specified on the Schedule of Benefits.

ARTICLE II - BENEFITS

A. PAYMENT

The payment for Benefits is subject to all terms and conditions of this Plan of Benefits. In the event of a conflict between the Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Oral statements cannot alter the terms of the Plan of Benefits or Schedule of Benefits. The Group Health Plan will only pay for Benefits:

1. Performed or provided on or after the Member effective date;

2. Performed or provided prior to termination of coverage;

3. Provided by a Provider within the scope of such Provider's license;

4. For which the required Preadmission Review, Emergency Admission Review, Preauthorization and/or Continued Stay Review has been requested and Preauthorization was received from the Corporation;

5. That are Medically Necessary;

6. That are not subject to an exclusion under Article III of this Plan of Benefits;

7. After the payment of all required Benefit Year Deductibles, Coinsurance and Copayments; and,

8. That comply with the Corporation's corporate medical policy unless otherwise indicated in the Benefit Detail Report.

The amount payable for Benefits is determined as set forth in this Plan of Benefits and on the Schedule of Benefits. Benefits are subject to the limitations and requirements set forth in this Plan of Benefits and on the Schedule of Benefits. Payment for Benefits will not exceed the Allowable Charge.

B. PREAUTHORIZATION

Some Benefits, as set forth on the Schedule of Benefits require Preauthorization to determine the Medical Necessity. The Group Health Plan reserves the right to add or remove Benefits that are subject to Preauthorization. If Preauthorization is not obtained, Benefits may be reduced or denied. Specific penalties are listed on the Schedule of Benefits. Preauthorization, where required, is obtained through the following procedures:

1. For all Admissions that are not the result of an Emergency Medical Condition, Preauthorization is granted or denied in the course of the Preadmission Review;

2. For all Admissions that result from an Emergency Medical Condition, Preauthorization is granted or denied in the course of the Emergency Admission Review;

3. For Admissions that are anticipated to require more days than approved through the initial review process, Preauthorization for additional days is granted or denied in the course of the Continued Stay Review;

4. For specific Benefits that require Preauthorization, Preauthorization is granted or denied in the course of the Preauthorization process; and,

5. For items requiring Preauthorization, the Corporation must be called at the numbers given on the Identification Card.

Preauthorization means only that the Corporation has determined that the Benefit is Medically Necessary. Preauthorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Member. Notwithstanding Preauthorization, payment for Benefits is subject to a Member's eligibility and all other limitations and exclusions contained in this Plan of Benefits. A Member's entitlement to Benefits is not determined until the Member's claim is processed.

C. SPECIFIC COVERED BENEFITS

In order for the Employer to pay for the Benefits described in Article II(D):

1. All of the requirements of Article II must be met;

2. The Benefit must be listed in Article II;

3. The Benefit must not have a "**Non-Covered**" notation associated with it on the Schedule of Benefits;

4. The Benefit (separately or collectively) must not exceed the dollar or other limitations contained on the Schedule of Benefits; and,

5. The Benefit must not be subject to one (1) or more of the exclusions set forth in Article III.

D. BENEFITS

ABA RELATED TO AUTISM SPECTRUM DISORDER

Benefits will be paid for ABA related to Autism Spectrum Disorder as set forth on the Schedule of Benefits.

ACUPUNCTURE

Benefits will be paid for acupuncture treatment or services as set forth on the Schedule of Benefits.

AMBULANCE SERVICES

Benefits will be paid for professional ground and air ambulance services to the nearest network Hospital in case of an accident or Emergency Medical Condition. The following requirements apply to all ground and air ambulance services and transports:

1. The transport is Medically Necessary and reasonable under the circumstances;

2. A Member is transported;

3. The destination is local within the United States; and,

4. The facility is medically appropriate to treat the Member's condition.

Benefits will be paid for ground ambulance transport between two Hospitals only when such ground ambulance transport has been Preauthorized and the Corporation confirms that the receiving Hospital is the closest facility that can provide medically appropriate care to treat the Member's condition. Transport from one facility to a new facility for the purpose of the Member obtaining a lower level of care at the new receiving facility must be Preauthorized. Repatriation for Member convenience is excluded and is not a Benefit for which Covered Expenses are payable.

Preauthorization is required for transportation as an inpatient from one Hospital to a second Hospital using an air ambulance. The following requirements must be met:

1. The first Hospital does not have the needed Hospital or skilled nursing care to treat the Member's illness or injury (such as burn care, cardiac care, trauma care, and critical care);

2. The second Hospital is the nearest medically appropriate facility to treat the Member's illness or injury;

3. A ground ambulance transport would endanger the Member's medical condition; and,

4. The transport is not related to a hospitalization outside the United States.

CARDIAC THERAPY

Benefits will be paid for cardiac therapy as set forth on the Schedule of Benefits.

CHIROPRACTIC SERVICES

Benefits will be paid for services and Medical Supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Benefits shall include but not be limited to:

1. Spinal manipulation/subluxation;

2. Related X-rays;

3. Modalities;

4. Office visits; and,

5. Unattended electrical stimulation, including Transcutaneous Electrical Nerve Stimulation (TENS) units when performed in the office.

CLEFT LIP OR PALATE

Benefits will be paid for care and treatment of a congenital cleft lip and/or palate and any physical condition or illness that is related to or developed as a result of a cleft lip or palate.

Benefits shall include but not be limited to:

1. Oral and facial Surgical Services, surgical management and follow-up care;

2. Prosthetic Device treatment, such as obturators, speech appliances and feeding appliances;

3. Orthodontic treatment and management;

4. Prosthodontia treatment and management;

5. Otolaryngology treatment and management;

6. Audiological assessment, treatment and management, including surgically implanted amplification devices; and,

7. Physical therapy assessment and treatment.

If a Member with a cleft lip or palate is covered by a dental policy, then teeth capping, prosthodontics and orthodontics shall be covered by the dental policy to the limit of coverage provided under such dental policy prior to coverage under this Group Health Plan. Excess medical expenses (after coverage under any dental policy is exhausted) shall be provided as for any other condition or illness under the terms and conditions of this Group Health Plan.

CLINICAL TRIALS

Benefits will be paid for routine Member costs for items and services related to Clinical Trials when:

1. The Member has cancer or other life-threatening disease or condition; and,

2. Either:

   a. the referring Provider is a Participating Provider that has concluded that the Member's participation in such trial would be appropriate; or,

   b. the Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate; and,

3. The services are furnished in connection with an approved Clinical Trial.

Examples of routine Member costs include, but are not limited to, radiological services, laboratory services, intravenous therapy, anesthesia services, Hospital services, Provider services, office visits, room and board, and Medical Supplies that typically would be covered under the Plan of Benefits for a Member who is not enrolled in a Clinical Trial.

COCHLEAR IMPLANTS

Benefits will be paid for unilateral or bilateral cochlear implantation of a U.S. Food and Drug Administration approved cochlear implant as set forth on the Schedule of Benefits.

CRANIAL ORTHOTICS

Benefits will be paid for adjustable cranial orthoses (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling surgery when Medically Necessary.

DENTAL ANESTHESIA AND OUTPATIENT FACILITY CHARGES RELATED TO DENTAL

Benefits will be paid for dental anesthesia and outpatient facility charges related to dental as set forth on the Schedule of Benefits.

DENTAL CARE FOR ACCIDENTAL INJURY

Benefits will be paid for dental services to Natural Teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force, such as a car accident or a blow by a moving object. No Benefits will be paid for injuries that occur while the Member is in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require Preauthorization; however, the dentist must submit a plan for any future treatment to the Corporation for review and Preauthorization before such treatment is rendered if Benefits are to be paid. Benefits are limited to treatment for only twelve (12) months from the date of the accidental injury.

DIABETES EDUCATION

Benefits will be paid for outpatient self-management training and education for Members with diabetes mellitus provided that such training and educational Benefits are rendered by a Provider whose program is recognized by the American Diabetes Association.

DIABETIC SHOES

Benefits will be paid for diabetic shoes as set forth on the Schedule of Benefits.

DURABLE MEDICAL EQUIPMENT

Benefits will be paid for Durable Medical Equipment, certain orthotics and supplies. Coverage is provided only for the cost of the item that meets minimum specifications and any amount that exceeds that cost will be the Member's responsibility. The Group Health Plan will decide whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Group Health Plan will not pay Benefits for Durable Medical Equipment that is solely used by a Member in a Hospital or that the Group Health Plan determines is included in any Hospital room charge.

EMERGENCY SERVICES

Benefits will be paid for the treatment of Emergency Medical Conditions. Benefits are only available to treat an Emergency Medical Condition provided on an outpatient basis at a Hospital emergency room or department and only for as long as the condition continues to be considered an Emergency Medical Condition, unless otherwise required by applicable law.

EYEGLASSES AND CONTACT LENSES

Benefits will be paid for eyeglasses and contact lenses as set forth on the Schedule of Benefits.

FORMULA AND FOOD PRODUCTS FOR PHENYLKETONURIA

Benefits will be paid for formula and food products for phenylketonuria as set forth on the Schedule of Benefits.

GENDER DYSPHORIA

Benefits will be paid for Medical Supplies, services or charges related to the diagnosis or medical treatment, excluding all gender affirming Surgical Services (please see Article II of the Plan of Benefits for coverage related to gender affirming Surgical Services), of gender dysphoria.

GENDER AFFIRMING SURGICAL SERVICES

Benefits will be paid for services related to gender affirming Surgical Services as outlined in the Corporation's medical policy and the Schedule of Benefits.

GYNECOLOGICAL EXAMINATION

Benefits will be paid for routine gynecological examinations each Benefit Year for female Members.

HABILITATION

Benefits will be paid for habilitation, including assisting a child with achieving developmental skills when impairments have caused delaying or blocking of initial acquisition of the skills. Habilitation can include fine motor, gross motor or other skills that contribute to mobility communication and performance of activities of daily living. The services will be described in an individual's plan of care.

HOME HEALTH CARE

Benefits will be paid for Home Health Care when rendered to a homebound Member in the Member's current place of residence.

HOSPICE CARE

Benefits will be paid for Hospice Care.

HOSPITAL SERVICES

Benefits will be paid for Admissions as follows:

1. Semiprivate room, board and general nursing care;

2. Private room, at semiprivate rate;

3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit rather than in another portion of the Hospital;

4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;

5. Diagnostic services, including interpretation of radiological and laboratory examinations, electrocardiograms and electroencephalograms; and,

6. In a Long-Term Acute Care Hospital.

Benefits for Admissions may be subject to the requirements for Preadmission Review, Emergency Admission Review and Continued Stay Review.

The day on which a Member leaves a Hospital, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Member returns to the Hospital by midnight of the same day. The day a Member enters a Hospital is treated as a day of Admission. The days during which a Member is not physically present for inpatient care are not counted as Admission days.

HUMAN ORGAN AND TISSUE TRANSPLANTS

1. Benefits will be paid for certain human organ and tissue transplants. To be covered, such transplants must be provided from a human donor to a Member and provided at a transplant center approved by the Group Health Plan. Benefits shall only be paid for the human organ and tissue transplants as set forth on the Schedule of Benefits.

2. The payment of Benefits for living donor transplants will be subject to the following conditions:

    a. When both the transplant recipient and the donor are Members, Benefits will be paid for both.

    b. When the transplant recipient is a Member and the donor is not, Benefits will be paid for both the recipient and the donor to the extent that the donor does not have health benefits provided by any other source.

    c. When the donor is a Member and the transplant recipient is not, no Benefits will be paid for either the donor or the recipient.

3. Human organ and tissue transplant coverage includes expenses incurred for legal donor organ and tissue procurement and all inpatient and outpatient Hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy and air ambulance expenses.

IN-HOSPITAL MEDICAL SERVICE

Benefits will be paid for a licensed medical doctor or Behavioral Health Clinician's visits to a Member during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or obstetrical service is required as follows:

1. In-Hospital medical Benefits primarily for Mental Health Services and Substance Use Disorder Services;

2. In-Hospital medical Benefits in a Skilled Nursing Facility will be provided for visits of a Provider, limited to one (1) visit per day, not to exceed the number of visits if set forth on the Schedule of Benefits;

3. Where two (2) or more Providers of the same general specialty render in-Hospital medical visits on the same day, payment for such services will be made only to one (1) Provider;

4. Concurrent medical and surgical Benefits for in-Hospital medical services are only provided:

    a. When the condition for which in-Hospital medical services requires medical care not related to Surgical Services or obstetrical service and does not constitute a part of the usual, necessary and related pre-operative or post-operative care but requires supplemental skills not possessed by the attending surgeon or such attending surgeon's assistant; and,

    b. When the surgical procedure performed is designated by the Group Health Plan as a warranted diagnostic procedure or as a minor surgical procedure.

5. When the same Provider renders different levels of care on the same day, Benefits will only be provided for the highest level of care.

INFERTILITY

Benefits will be paid for the diagnosis of and testing for infertility and treatment of the underlying condition causing infertility.

MAMMOGRAPHY TESTING

Benefits will be paid for mammography testing, regardless of Medical Necessity, as set forth on the Schedule of Benefits. Benefits will be paid for additional mammograms during a Benefit Year based on Medical Necessity.

MASTECTOMIES AND RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

Benefits will be paid for mastectomies. The Group Health Plan may not restrict Benefits for a Hospital length of stay following a mastectomy to less than forty-eight (48) hours. Nothing in this paragraph prohibits the attending Provider, after consulting with the Member, from discharging the Member earlier than forty-eight (48) hours. In the case of an early release, Benefits will be paid for one (1) home care visit if ordered by the attending Provider.

In the case of a Member who is receiving Benefits in connection with a mastectomy, Benefits will be paid for each of the following (if requested by such Member):

1. Reconstruction of the breast on which the mastectomy has been performed;

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

3. Prosthetic Devices and physical complications at all stages of the mastectomy, including lymphedema.

MEDICAL SUPPLIES

Benefits will be paid for Medical Supplies, provided that the Group Health Plan will not pay Benefits separately for Medical Supplies that are or should be provided as part of another Benefit.

MENTAL HEALTH SERVICES

Benefits will be paid for Mental Health Services provided on an inpatient or outpatient basis.

OBSTETRICAL SERVICES

Benefits will be paid for obstetrical services. Notwithstanding the preceding, Benefits for maternity or obstetrical services will not be paid for a Member who is a child except for life-threatening pregnancy complications to either the mother or fetus. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.

Under the terms of the Newborn and Mother's Health Act of 1996, the Group Health Plan generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery) or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or the mother's newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the Group Health Plan may not require that a Provider obtain authorization from the Corporation for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. However, Preauthorization is required to use certain Providers or facilities or to reduce out-of-pocket costs.

ORTHOGNATHIC SURGERY

Benefits will be paid for any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication or orthognathic deformities for which the resulting disorder is breathing, nutritional or speech related. Services exclude dental conditions related to biting, chewing or teeth.

ORTHOPEDIC DEVICES

Benefits will be paid for Orthopedic Devices.

ORTHOTIC DEVICES

Benefits will be paid for Orthotic Devices that are not available on an over-the-counter basis and are not otherwise excluded under this Plan of Benefits.

ORTHOPTIC TRAINING

Benefits will be paid for orthoptic training as set forth on the Schedule of Benefits.

OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES

Benefits will be paid for Surgical Services and diagnostic services including radiological examinations, laboratory tests and machine tests, performed in an outpatient Hospital setting or an Ambulatory Surgical Center.

OUTPATIENT REHABILITATION SERVICES

Benefits will be paid, subject to the following paragraph, for physical therapy, occupational therapy and rehabilitation services as set forth on the Schedule of Benefits.

Benefits for outpatient rehabilitation services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.

OXYGEN

Benefits will be paid for oxygen. Durable Medical Equipment for oxygen use in a Member's home is covered under the Durable Medical Equipment Benefit.

PAP SMEAR

Benefits will be paid for a Pap smear as part of a gynecological examination regardless of Medical Necessity. Benefits will be paid for additional Pap smears during a Benefit Year based on Medical Necessity.

PENILE IMPLANT

Benefits will be paid for penile implant as set forth on the Schedule of Benefits.

PHYSICAL EXAMINATION

Benefits will be paid for physical examinations for Members.

PREVENTIVE SERVICES

Benefits will be paid for preventive health services required under the ACA as follows:

1. Evidence based services that have a rating of A or B in the current United States Preventive Services Task Force (USPSTF) recommendations;

2. Immunizations as recommended by the CDC; and,

3. Preventive care and screenings for children and women as recommended by the Health Resources and Services Administration (HRSA).

These Benefits are paid without any cost-sharing by the Member when the services are provided by a Participating Provider. Any other covered preventive screenings will be provided as set forth on the Schedule of Benefits.

PROSTATE EXAMINATION

Benefits will be paid for prostate examinations per Benefit Year regardless of Medical Necessity as set forth on the Schedule of Benefits. Benefits will be paid for additional prostate examinations during a Benefit Year based on Medical Necessity.

PROSTHETIC DEVICES

Benefits will be paid for a Prosthetic Device, other than a dental or cranial prosthetic, which is a replacement for a body part and which meets minimum specifications for the body part it is replacing regardless of the functional activity level. Coverage is provided for only the cost of the item that meets minimum specifications and any amount that exceeds that cost will be the Member's responsibility. Benefits are provided for only the initial temporary prosthesis and one (1) permanent prosthesis.

PROVIDER SERVICES

Benefits will be paid for Provider Services, provided that when different levels of Provider Services are provided on the same day, Benefits will only be paid for the highest level of Provider Services.

PULMONARY THERAPY

Benefits will be paid for pulmonary therapy as set forth on the Schedule of Benefits.

REHABILITATION

Benefits will be paid, as specified on the Schedule of Benefits, for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment if the following criteria are met:

1. All such treatment must be ordered by a licensed medical doctor;

2. All such treatment must be performed by a Provider and at a location designated by the Group Health Plan;

3. Preauthorization must be obtained, if required;

4. The documentation that accompanies a request for rehabilitation meets the criteria outlined in the Corporation's medical policy; and,

5. All such rehabilitation Benefits are subject to periodic review by the Group Health Plan.

After the initial rehabilitation period, continuation of rehabilitation Benefits will require documentation that the Member is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

RESIDENTIAL TREATMENT CENTERS

Benefits will be paid for Residential Treatment Centers as set forth on the Schedule of Benefits.

SKILLED NURSING FACILITY SERVICES

Benefits will be paid for Admissions in a Skilled Nursing Facility as follows:

1. Semiprivate room, board, and general nursing care;

2. Private room, at semiprivate rate;

3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit;

4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;

5. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; and,

6. In a Long-Term Acute Care Hospital.

Benefits for Admissions may be subject to the requirements for Preadmission Review, Emergency Admission Review, and Continued Stay Review.

The day on which a Member leaves a Skilled Nursing Facility, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Member returns to the Skilled Nursing Facility by midnight of the same day. The day a Member enters a Skilled Nursing Facility is treated as a day of Admission. The days during which a Member is not physically present for inpatient care are not counted as Admission days.

SPECIALTY DRUGS

Certain Specialty Drugs may be considered medical Benefits and may:

1. Require Preauthorization; and/or,

2. Be subject to certain place of service requirements.

For any Specialty Drugs paid as medical Benefits, the Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit maximum will apply as set forth on the Schedule of Benefits. A list of Specialty Drugs as well as information about any related requirements and/or restrictions may be obtained by contacting the Corporation at the number listed on the Identification Card or at https://www.MyHealthToolkitKC.com/.

SPEECH THERAPY

Benefits will be paid for speech therapy as set forth on the Schedule of Benefits.

SUBSTANCE USE DISORDER SERVICES

Benefits will be paid for Substance Use Disorder Services as set forth on the Schedule of Benefits.

SURGICAL SERVICES

Benefits will be paid for Surgical Services performed by a licensed medical doctor or oral surgeon, as applicable, for treatment and diagnosis of disease or injury or for obstetrical services, as follows:

1. Surgical Services, subject to the following:

    a. If two (2) or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only.

    b. If two (2) or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure bearing the highest Allowable Charge plus one-half (1/2) of the Allowable Charge for all other operations or procedures performed.

    c. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, fifty percent (50%) for the procedure bearing the second and third highest Allowable Charges, twenty-five percent (25%) for the procedures bearing the fourth through the eighth highest Allowable Charges and ten percent (10%) for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge and fifty percent (50%) of the charge for each subsequent procedure.

    d. If an operation or procedure is performed in two (2) or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure.

e. If two (2) or more licensed medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant surgeon or anesthesiologist, the Allowable Charge, subject to the above paragraphs, will be coverage for the services of only one (1) licensed medical doctor or oral surgeon (as applicable) or will be prorated between them by the Group Health Plan when so requested by the licensed medical doctor or oral surgeon in charge of the case.

f. Certain surgical procedures are designated as separate procedures by the Group Health Plan. The Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowable Charge for the major procedure only.

2. Assistant Surgeon services that consists of the Medically Necessary service of one (1) licensed medical doctor, oral surgeon, physician assistant or nurse practitioner who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital and when such surgical assistant service is not available by an intern, resident or in-house physician. The Group Health Plan will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the licensed medical doctor's or oral surgeon's (as applicable) actual charge.

3. Anesthesia services that consist of services rendered by a licensed medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or such attending surgeon's assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

SUSTAINED HEALTH BENEFITS

Benefits will be paid for certain routine annual Benefits (known as Sustained Health Benefits) as set forth on the Schedule of Benefits. These Benefits are designed to cover costs associated with routine care and are provided in addition to the Preventive Services covered under the ACA. Because these are additional Benefits, age and monetary limitations may be imposed and cost-sharing may be required by the Member.

TELEHEALTH

Benefits will be paid for Telehealth services which are initiated by either a Member or Provider and are provided by licensed health care professionals who have been credentialed as eligible Telehealth Providers.

TELEMEDICINE

Benefits will be paid for Telemedicine services as follows:

Office and outpatient visits that are conducted via Telemedicine are counted towards any applicable Benefit limits for these services.

Consulting and referring Providers must be Participating Providers who have been credentialed as eligible Telemedicine Providers.

Telemedicine services will be covered by the Group Health Plan under the following circumstances:

1. The medical care is individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the Member's need; and,

2. The medical care can be safely furnished, and there is no equally effective, more conservative and less costly treatment available.

Examples of interactions that are not reimbursable Telemedicine services and will not be reimbursed are:

1. Telephone conversations;

2. Email messages;

3. Facsimile transmissions; or,

4. Internet-based audio-video communication that is not secure and HIPAA-compliant (e.g., Skype).

TEMPOROMANDIBULAR JOINT (TMJ) DISORDER

Benefits will be paid for the treatment of dysfunctions or derangements of the temporomandibular joint, including orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint.

TOOTH EXTRACTIONS AND DENTAL IMPLANTS

Benefits will be paid for tooth extractions and dental implants as set forth on the Schedule of Benefits and as follows:

1. Extraction of the tooth (teeth) and services related to such extraction(s) when performed in conjunction with the treatment of head and/or neck tumor(s).

2. Dental implants and bone grafts for the following conditions:

   a. The repair of defects in the jaw due to tumor/cyst removal;

   b. Severe atrophy in a toothless arch;

   c. Exposure of nerves;

   d. Non-union of a jaw fracture;

   e. Loss of tooth (teeth) due to an accidental injury; and

   f. Correction of a defect diagnosed within thirty-one (31) days of birth.

3. Dental prostheses over an implant are not covered unless the dental implant was due to an accidental injury or due to a correction of a defect within thirty-one (31) days of birth.

TRAVEL AND LODGING

Benefits will be paid for travel and lodging related to a human organ or tissue transplant for donors and recipients as set forth on the Schedule of Benefits.

ARTICLE III - EXCLUSIONS AND LIMITATIONS

THE EMPLOYER'S GROUP HEALTH PLAN WILL NOT PAY ANY AMOUNT FOR THE SERVICES AND PRODUCTS LISTED IN THIS ARTICLE III EXCEPT: (1) SERVICES ARE RENDERED BY A HEALTH CARE PROVIDER AS PART OF A VALUE-BASED PROGRAM OR (2) IF REQUIRED BY LAW.

ABORTIONS

Charges for elective abortions.

ACTS OF WAR

Illness contracted or injury sustained as a result of a Member's participation as a combatant in a declared or undeclared war, or any act of war, or while in military service.

AMBULANCE

Ambulance services:

1. That do not meet coverage guidelines outlined in the Ambulance Services description in Article II;

2. That are not Medically Necessary and reasonable;

3. For transport to a more distant Hospital solely for the Member's convenience, regardless of the reason, or to allow the Member to use the services of a specific Provider or Specialist. The Group Health Plan will pay the base rate and mileage for a Medically Necessary ambulance transport to the nearest medically appropriate facility. If the transport is to a facility that is not the nearest medically appropriate facility, the Member is responsible for additional cost incurred to go to the Member's preferred facility;

4. If the Member is medically stable and the situation does not involve an emergency, except as specified in Article II; or,

5. For transport from a Hospital in connection with a hospitalization outside the United States.

Any and all travel expenses including, but not limited to, transportation, lodging and repatriation are excluded.

AUTO ACCIDENTS

This Plan of Benefits does not provide coverage for claims paid or payable under an automobile insurance policy or any other type of liability insurance policy. Automobile insurance policies include, but are not limited to, no fault, personal injury protection, medical payments, liability, uninsured and underinsured policies, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.

BEHAVIORAL, EDUCATIONAL OR ALTERNATE THERAPY PROGRAMS

Any behavioral, educational or alternative therapy techniques to target cognition, behavior language and social skills modification, including:

1. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
2. Higashi schools/daily life;
3. Facilitated communication;
4. Floor time;
5. Developmental Individual-Difference Relationship-based model (DIR);
6. Relationship Development Intervention (RDI);
7. Group socialization;
8. Primal therapy;
9. Holding therapy;
10. Movement therapy;
11. Art therapy;
12. Dance therapy;
13. Music therapy;
14. Animal assisted therapy;
15. Sexual conversion therapy; and,
16. Cranial electrical stimulation (CES).

BENEFITS PROVIDED BY STATE OR FEDERAL PROGRAMS

Any service or charge for a service to the extent that the Member is entitled to payment or benefits relating to such service under any state or federal program that provides healthcare benefits, including, but not limited to, Medicare, TRICARE and Medicaid, but only to the extent that benefits are paid or are payable under such programs. This exclusion includes, but is not limited to, benefits provided by the Veterans Administration for care rendered for a service-related disability or any state or federal Hospital services for which the Member is not legally obligated to pay.

CLINICAL TRIAL

Any of the following:

1. Services that are not covered routine patient care costs or services, including the following:

    a. The investigational drug, device, item or service that is provided solely to satisfy data collection and analysis needs;

    b. An item or service that is not used in the direct clinical management of the Member; and,

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

2. An item or service provided by the research sponsors free of charge for any person enrolled in the Clinical Trial; and,

3. Travel and transportation expenses unless otherwise covered under the Plan of Benefits, including, but not limited to:

    a. Fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline or train;

    b. Mileage reimbursement for driving a personal vehicle;

    c. Lodging; and,

    d. Meals.

COMPLICATIONS FROM NON-COVERED SERVICES

Complications arising from a Member's receipt or use of services, Medical Supplies or other treatment that are not Benefits.

CONTRACEPTIVES

Medical Supplies, services, devices or Prescription Drugs of any type even those dispensed by a prescription, for the purpose of contraception, except as specified on the Schedule of Benefits.

COPYING CHARGES

Fees for copying or production of medical records and/or claims filing.

COSMETIC AND RECONSTRUCTIVE SERVICES

A. This Plan of Benefits excludes cosmetic or reconstructive procedures, and any related services or Medical Supplies, which alter appearance but do not restore or improve impaired physical function. Examples of services that are cosmetic or reconstructive which are not covered include, but are not limited to, the following:

    1. Rhinoplasty (nose);

    2. Mentoplasty (chin);

3. Rhytidoplasty (face lift);

4. Glabellar rhytidoplasty (forehead lift);

5. Surgical planing (dermabrasion);

6. Blepharoplasty (eyelid);

7. Mammoplasty (reduction, suspension or augmentation of the breast);

8. Superficial chemosurgery (chemical peel of the face);

9. Rhytidectomy (abdomen, legs, hips, buttocks or elsewhere including lipectomy or adipectomy).

B. A cosmetic or reconstructive service may, under certain circumstances, be considered restorative in nature for which Benefits are available but only if the following requirements are met:

1. The service is intended to correct, improve or restore a bodily function; or,

2. The service is intended to correct, improve or restore a malappearance or deformity that was caused by physical injury or accident, congenital anomaly or covered Surgical Service; and,

3. The proposed service is Preauthorized.

CUSTODIAL CARE

Services or supplies related to Custodial Care, except as specified on the Schedule of Benefits.

DENTAL SERVICES

Any dental procedures involving tooth structures, excision or extraction of teeth, gingival tissue, alveolar process, dental X-rays, preparation of mouth for dentures, or other procedures of dental origin. However, that such procedures may be covered if the need for dental services results from an accidental injury within twelve (12) months prior to the date of such services.

FOOD SUPPLEMENTS

Orthomolecular therapy, including infant formula, nutrients, vitamins and food supplements. Enteral feedings when not a sole source of nutrition, except as specified on the Schedule of Benefits.

FOOT CARE

Routine foot care such as paring, trimming or cutting of nails, calluses or corns, except in conjunction with diabetic foot care.

HAIR REPLACEMENTS

Wigs, hairpieces and any other artificial substitute for scalp hair.

HEARING AIDS AND EXAMS

Hearing aids and examinations for the prescription or fitting of hearing aids.

HUMAN ORGAN AND TISSUE TRANSPLANTS

Human organ and tissue transplants that are not:

1. Preauthorized, if required, as set forth on the Schedule of Benefits;

2. Performed by a Provider as designated by the Corporation; and,

3. Listed as covered on the Schedule of Benefits.

ILLEGAL ACTS

Any illness or injury received, directly or indirectly, related to and/or contributed to, in whole or in part, while committing or attempting to commit a felony or while engaging or attempting to engage in an illegal act or occupation.

IMPACTED TOOTH REMOVAL

Services or Medical Supplies for the removal of impacted teeth.

IMPOTENCE

Services, supplies or drugs related to any treatment for impotence, including but not limited to penile implants.

INCAPACITATED DEPENDENTS

Any service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum dependent child age, unless covered under a prior Plan.

INPATIENT DIAGNOSTIC AND EVALUATIVE PROCEDURES

Inpatient care and related Provider Services rendered in conjunction with an Admission which is principally for diagnostic studies or evaluative procedures that could have been performed on an outpatient basis are not covered unless the Member's medical condition alone required Admission.

INTOXICATION OR DRUG USE

Any service (other than Substance Use Disorder Services), Medical Supplies, charges or losses directly or indirectly resulting from, related to and/or contributed to, in whole or in part, a Member being Legally Intoxicated or under the influence of alcohol, chemicals, narcotics, drugs and/or other substances, or taking some action the purpose of which is to create a euphoric state or alter consciousness. The Member, or Member's representative, must provide any available test results showing blood alcohol, chemical, narcotic, drug and/or substance levels upon request by the Corporation. If the Member refuses to provide these test results, no Benefits will be provided.

INVESTIGATIONAL OR EXPERIMENTAL SERVICES

Services or supplies or drugs that are Investigational or Experimental.

LIFESTYLE IMPROVEMENT SERVICES

Services or supplies relating to lifestyle improvements, including, but not limited to, physical fitness programs.

LONG-TERM CARE SERVICES

Admissions or portions thereof for long-term care, including:

1. Rest care;

2. Care to assist a Member in the performance of activities of daily living (including, but not limited to, walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication);

3. Custodial or long-term care; or,

4. Psychiatric or Substance Use Disorder treatment, including, but not limited to, behavioral modification facilities, wilderness programs, boot camps, emotional group academies, military schools, therapeutic boarding schools, half-way houses and group homes.

MEMBERSHIP DUES AND OTHER FEES

Amounts payable (whether in the form of initiation fees, annual dues or otherwise) for membership or use of any gym, workout center, fitness center, club, golf course, wellness center, health club, weight control organization or other similar entity or payable to a trainer of any type.

MOTORIZED WHEELCHAIRS OR POWER OPERATED VEHICLES

Motorized wheelchairs or power operated vehicles, such as scooters for mobility outside of the home setting, except as specified on the Schedule of Benefits. Coverage for these devices to assist with mobility in the home setting is subject to the establishment of Medical Necessity.

NOT MEDICALLY NECESSARY SERVICES OR SUPPLIES

Any service or supply that is not Medically Necessary. However, if a service is determined to be not Medically Necessary because it was not rendered in the least costly setting, Benefits may be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.

NUTRITIONAL COUNSELING

Nutritional counseling.

OBESITY RELATED SERVICES

1. Services, supplies, treatment or medication for the management of obesity or morbid obesity.

2. Surgical procedures for the treatment of morbid obesity, including services, supplies and charges for the treatment of complications from or reversal of such procedures.

3. Membership fees to weight control programs, except as specified on the Schedule of Benefits.

OVER-THE-COUNTER DRUGS

Drugs that are available on an over-the-counter basis or are otherwise available without a prescription.

PAIN MANAGEMENT

Services, supplies or charges for any kind of pain management, including but not limited to, wellness or alternative treatment programs, massage therapy and hypnotism. The Corporation may, in its discretion under certain limited circumstances, approve services for an interdisciplinary pain management program, as defined herein. An interdisciplinary pain management program is a program that includes physicians of different specialties and non-physician Providers who specialize in the assessment and management of patients with a range of painful diagnoses and chronic pain, the purpose of which is intended to provide the interventions needed to allow the patients to develop pain coping skills and discontinue analgesic medication. Services, supplies or charges for an interdisciplinary pain management program must be Preauthorized in advance. Preauthorization approval shall be on a case by case basis, in the discretion of the Corporation, and contingent upon such program, and the Providers offering such program, complying with the Corporation's Provider credentialing and medical policy requirements, which may change from time to time based on new evidence-based medical information available to the Corporation. The Member is solely responsible for seeking Preauthorization in advance, regardless of the state of location of the Provider offering the interdisciplinary pain management program.

PARTICIPATING PROVIDER CHARGES NOT PREAUTHORIZED

For any service that requires Preauthorization, the penalty for not obtaining Preauthorization will vary from state to state, depending on the contractual agreements the BCBS Plan has with its local Providers in that state. Generally, this is a penalty to the Provider, but in some cases, the Member may be held liable.

PHYSICAL THERAPY ADMISSIONS

All Admissions solely for physical therapy, except as provided in Article II.

PREGNANCY OF A DEPENDENT CHILD

A covered dependent child's pregnancy, including childbirth, except for life-threatening pregnancy complications to either the mother or fetus.

PREOPERATIVE ANESTHESIA CONSULTATION

Charges for preoperative anesthesia consultation.

PRESCRIPTION DRUGS

Charges for Prescription Drugs.

PRIVATE DUTY NURSING

PDN services.

PROVIDER CHARGES

Charges by a Provider for blood and blood derivatives and for charges for Prescription Drugs or Specialty Drugs that are not consumed at the Provider's office.

PSYCHOLOGICAL AND EDUCATIONAL TESTING

Psychological or educational diagnostic testing to determine job or occupational placement, school placement or for other educational purposes or to determine if a learning disability exists.

REPATRIATION

Services and supplies received as the result of transporting a Member, regardless of cause, from a foreign country for the convenience of the Member or to the Member's residence in the United States.

SELF-INFLICTED INJURY

Services and supplies received as the result of any intentionally self-inflicted injury that does not result from a medical condition or domestic violence.

SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS

Medical Supplies or services or charges for the diagnosis or treatment of learning disorders, communication disorders, motor skills disorders, intellectual disabilities, vocational rehabilitation, relational problems or rapid opiate detoxification, except as specified on the Schedule of Benefits.

SERVICES FOR COUNSELING OR PSYCHOTHERAPY

Counseling and psychotherapy services for the following conditions are not covered:

1. Tic disorders, except when related to Tourette's disorder;
2. Mental disorders due to a general medical condition;
3. Medication induced movement disorders; or,
4. Nicotine dependence, except as specified on the Schedule of Benefits.

SERVICES NOT LISTED AS COVERED BENEFITS

Medical Supplies or services or other items not specifically listed as a Benefit in Article II of this Plan of Benefits or on the Schedule of Benefits.

SERVICES PRIOR TO MEMBER EFFECTIVE DATE OR PLAN OF BENEFITS EFFECTIVE DATE

Any charges for Medical Supplies or services rendered to the Member prior to the Member's effective date, the Employer's Effective Date or after the Member's coverage terminates.

SERVICES RENDERED BY FAMILY

Any Medical Supplies or services rendered by a Member to themselves or rendered by a Member's immediate family (parent, child, spouse, brother, sister, grandparent or in-law).

SERVICES REQUIRING PREAUTHORIZATION FOR WHICH SUCH PREAUTHORIZATION IS NOT OBTAINED

If Preauthorization is required for an otherwise Covered Expense: and such Preauthorization is not obtained, Benefits may be reduced or denied as set forth on the Schedule of Benefits.

TRAVEL

Travel, whether or not recommended by a Provider unless directly related to human organ or tissue transplants for donors and recipients when Preauthorized and except as specified on the Schedule of Benefits.

VARICOSE VEIN AND VEINOUS INSUFFICIENCY TREATMENT

Services, supplies or treatment for varicose veins and/or any venous insufficiency condition, including, but not limited to, endovenous ablation, vein stripping, or the injection of sclerosing solutions.

VISION CARE SERVICES

Any Medical Supply or service rendered to a Member for vision care, except as specified on the Schedule of Benefits.

WORKERS' COMPENSATION/ON THE JOB INJURIES

This Plan of Benefits does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage is available under any Workers' Compensation Act or similar federal or state law regarding on the job injuries is required or is otherwise available for the Member. Benefits will not be provided under this Plan of Benefits if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member or Employer elected exemption from available workers' compensation coverage, waived entitlement to workers' compensation benefits for which the Member is eligible, failed to timely file a claim for workers' compensation benefits or the Member sought treatment for the injury or illness from a Provider which is not authorized by the Member's Employer or Workers' Compensation Carrier.

If the Group Health Plan pays Benefits for an injury or illness and the Group Health Plan determines the Member also received a recovery from the Employer or Employer's Workers' Compensation Carrier by means of a settlement, judgment or other payment for the same injury or illness, the Group Health Plan shall have the right of recovery as outlined in Article VII of this Plan of Benefits.

ARTICLE IV - COORDINATION OF BENEFITS

A. APPLICABILITY

The coordination of benefits rules are intended to prevent duplicate payments from different Plans that otherwise cover a Member for the same Benefits. The rules determine which is the Primary Plan and which is the Secondary Plan.

Generally, unless a specific rule applies, where a claim is submitted for payment under this Plan of Benefits and one (1) or more other Plans, this Plan of Benefits is the Secondary Plan. Additionally, special rules for the coordination of benefits with Medicare may also apply. The Group Health Plan does not coordinate benefits with individual Plans.

B. COORDINATION OF BENEFITS WITH AUTO INSURANCE

This is a self-funded ERISA Plan which does not provide benefits for claims which are paid or payable under automobile insurance coverage. Automobile insurance coverage shall include, but is not limited to, no-fault, personal injury protection, medical payments, liability, uninsured and underinsured coverage, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.

Although benefits for claims which are paid or payable under automobile insurance coverage are not covered by this Plan of Benefits, the Group Health Plan or Corporation may, in its sole discretion, agree to extend Benefits to a Member for the injury or illness. In this instance, if a Member has automobile no-fault, personal injury protection or medical payments coverage, or if such coverage is extended to the Member through a group or their own automobile insurance carrier, that coverage is primary to the Group Health Plan. The Group Health Plan will always be secondary to automobile no-fault, personal injury protection or medical payments coverage plans and the Group Health Plan will coordinate benefits for claims which are payable under those automobile policies.

If the Member resides in a state where automobile no-fault, personal injury protection or medical payments coverage is mandatory and the Member does not have the state mandated automobile coverage, the Group Health Plan will deny Benefits up to the amount of the state mandated automobile coverage.

This coordination of benefits provision applies whether or not the Member submits a claim under the automobile no-fault, personal injury protection or medical payments coverage.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Group Health Plan or Corporation of an injury or illness for which automobile insurance coverage may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;

2. Execute and deliver to the Corporation an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

3. Deliver to the Group Health Plan or Corporation a copy of your Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;

4. Deliver to the Group Health Plan or Corporation a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so; and,

5. Cooperate fully with the Group Health Plan or Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Group Health Plan or Corporation.

Failure to cooperate with the Group Health Plan as required under this section will entitle the Group Health Plan or Corporation to invoke the Auto Accident Exclusion and deny payment for all claims relating to the injury or illness up to the amount of available or state mandated coverage.

C. ORDER OF DETERMINATION RULES FOR EMPLOYEE MEMBERS

When a Member's claim is submitted under the Group Health Plan and another Plan, the Group Health Plan is a Secondary Plan unless:

1. The other Plan has rules coordinating its benefits with those of the Group Health Plan;

2. There is a statutory requirement establishing that the Group Health Plan is the Primary Plan and such statutory requirement is not pre-empted by ERISA; or,

3. Both the other Plan's rules and the Group Health Plan's rules require that Benefits under this Plan of Benefits be determined before those of the other Plan.

D. ADDITIONAL ORDER OF DETERMINATION RULES

The coordination of benefits is determined using the first of the following rules that apply:

1. Dependents

    a. The Plan that covers an individual as an Employee or retiree is the Primary Plan.

2. Dependent Child - Parents not Separated or Divorced

    When the Group Health Plan and another Plan cover the same child as a dependent then benefits are determined in the following order:

    a. The Plan of the parent whose birthday falls earlier in the year (month and date) is the Primary Plan.

    b. If both parents have the same birthday, the Plan that has covered a parent longer is the Primary Plan.

    c. If the other Plan does not have the rule described in (a) above but instead has a rule based upon the gender of the parent and if, as a result, the Plan and the Corporation do not agree on the order of benefits, the gender rule in the other Plan will apply.

    The "birthday rule" does not use the years of the parents' birth in determining which has the earlier birthday.

3. Dependent Child - Separated or Divorced Parents

    If two (2) or more Plans cover a person as a dependent child of divorced, separated or unmarried parents, benefits for the child are determined in the following order:

    a. First, the Plan of the parent with custody of the child;

    b. Second, the Plan of the parent's spouse with the custody of the child;

    c. Third, the Plan of the parent not having custody of the child; or,

    d. Fourth, the Plan of the parent's spouse not having custody of the child.

Notwithstanding the foregoing, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses (or health insurance coverage) of the child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, that Plan is the Primary Plan. If the parent with responsibility for healthcare expenses has no health insurance coverage for the dependent child, but that parent's spouse does have coverage, the spouse's Plan is the Primary Plan. This paragraph does not apply with respect to any claim determination period or Plan year during which any Benefits are actually paid or provided before the Plan has actual knowledge of the existence of an applicable court decree.

If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the healthcare expenses of the child (or if the order provides that both parents are responsible), the Plans covering the child shall follow the order of determination rules outlined in Article IV(D)(2). Once the dependent child reaches the age of eighteen (18) and/or the terms of the court decree are no longer applicable, the Plan which has covered the dependent for a longer period of time will be primary.

4. Active and Inactive Employees

   The benefits of the Plan that covers a person as an Employee who is neither laid off nor retired or as that Employee's dependent is the Primary Plan. If the Secondary Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Covered Expenses, this rule does not apply.

5. Medicare

   The Group Health Plan is a Primary Plan except where federal law mandates that the Group Health Plan is the Secondary Plan. Any claims where Medicare is primary must be filed by the Member after Medicare payment is made.

6. Longer and Shorter Length of Coverage

   If none of the above rules determines the order of benefits, the Plan that has covered the Member longer is the Primary Plan.

7. Continuation Coverage

   In instances where a Member is covered by this Group Health Plan and other employer-sponsored coverage and only one of them is continuation coverage (*e.g.*, COBRA or other continuation coverage), such continuation coverage will be the Secondary Plan.

E. EFFECT ON BENEFITS OF THIS PLAN OF BENEFITS

1. The Group Health Plan as Primary Plan

   When the Group Health Plan is the Primary Plan, the Benefits shall be determined without consideration of the benefits of any other Plan.

2. The Group Health Plan as Secondary Plan

   When the Group Health Plan is a Secondary Plan, the Benefits will be reduced when the sum of the following exceeds the Covered Expenses in a Benefit Year:

   a. The Covered Expenses in the absence of this coordination of benefits provision; plus

   b. The expenses that would be payable under the other Plan, in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not a claim is made.

   When the sum of these two (2) amounts exceeds the maximum amount payable for Covered Expenses in a Benefit Year, the Covered Expenses will be reduced so that they and the Benefits payable under the Primary Plan do not total more than the Covered Expenses. When the Covered Expenses of the Group Health Plan are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of the Group Health Plan. The benefits payable by the Primary Plan and the Benefits payable by the Group Health Plan will not total more than what the Group Health Plan would pay in absence of the other plan.

3. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered for purposes of determining the appropriate level of coverage available.

4. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not a Covered Expense unless the Member's Admission in a private Hospital room is Medically Necessary. When benefits are reduced under a Primary Plan because a Member does not comply with the Primary Plan's requirements, the amount of such reduction in benefits will not be a Covered Expense.

F. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

The Group Health Plan (including through the Corporation) is entitled to such information as it deems reasonably necessary to apply these coordination of benefit provisions, and the Member and the Employer must provide any such information as reasonably requested.

G. PAYMENT

A payment made under another Plan may include an amount that should have been paid under the Group Health Plan. In such a case, the Group Health Plan may pay that amount to the organization that made such payment. That amount will then be treated as though it has been paid under the Group Health Plan. The term "payment" includes providing Benefits in the form of services, in which case "payment" means the reasonable cash value of the Benefits provided in the form of services.

H. RIGHT OF RECOVERY

If the amount of the payments made by the Group Health Plan is more than the Group Health Plan should have paid, the Group Health Plan may recover the excess or overpayment from the Member on whose behalf it has made payments, from a Provider, any group insurer, Plan, or any other person or organization contractually obligated to such Member with respect to such overpayments.

ARTICLE V – CONTINUATION OF COVERAGE

A. CONTINUATION

1. COBRA

   a. Plan Administrator and Sponsor

      The Employer is both the Plan Administrator and Plan Sponsor for the Group Health Plan. The Employer agrees to offer continuation of coverage pursuant to the provisions of COBRA, if required, to eligible Members while the Group Health Plan is in force. COBRA requires the Employer to allow eligible individuals to continue their health coverage for eighteen (18), twenty-nine (29) or thirty-six (36) months, depending on the Qualifying Event.

   b. Disabled Members

      To be eligible for up to twenty-nine (29) months of continuation of coverage due to disability, an Employee or dependent who:

      i. is determined to be disabled under Title II or XVI of the Social Security Act,

      ii. with a disability onset date either before the COBRA event or within the first sixty (60) days of the COBRA continuation coverage must provide a copy of the notice of the determination of disability to the Employer within:

         aa. sixty (60) days of the determination of disability; and,

         bb. before the end of the first eighteen (18) months of COBRA coverage.

      Such Employee or dependent must also notify the Employer within thirty (30) days of any determination that the Employee or dependent is no longer disabled.

   c. Notice of Qualifying Event by the Member

      Each Member is responsible for notifying the Employer within sixty (60) days of such Member's Qualifying Event due to divorce, legal separation or when a dependent ceases dependency. If the Member does not give such notice, the Member is not entitled to continuation coverage.

   d. Notice by the Employer to the Member

      The Employer must notify the COBRA Administrator no later than thirty (30) days after the date the Member loses coverage due to a COBRA event. The COBRA Administrator must send a COBRA Election Notice to each Member no later than fourteen (14) days after receipt of the notice from the Employer. Notice to the dependent spouse is deemed notice to any dependent of the spouse.

e. Election of Coverage

Continuation coverage is not automatic. The Member must elect continuation coverage within sixty (60) days of the later of:

i. The date the Member's coverage under the Group Health Plan ceases because of the Qualifying Event;

ii. The date the Member is sent notice by the Employer of the right to elect continuation coverage; or,

iii. The date the Member becomes an "eligible individual" (as that term is used in the Trade Act of 2002) provided that such election is made not later than six (6) months after the Qualifying Event that gives rise to eligibility under the Trade Act of 2002 (TAA).

f. Premium Required

The Member will be required to pay a premium for the continuation coverage and shall have the option to make payment in monthly installments. The Member has forty-five (45) days from the date of election to pay the first premium, which includes the period when coverage commenced, regardless of the date that the first premium is due.

The TAA created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of a percentage of the premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll free at 866-628-4282. TTD/TTY callers may call toll free at 866-626-4282. More information about the TAA is also available at www.doleta.gov/tradeact/.

g. Length of COBRA Coverage

The maximum period for continuation coverage for a Qualifying Event involving termination of employment or a reduction in hours is generally eighteen (18) months. An Employee or dependent who is determined to be disabled under Title II or XVI of the Social Security Act before the COBRA event or within the first sixty (60) days of COBRA continuation coverage is entitled to twenty-nine (29) months of continuation coverage, but only if such Employee or dependent has provided notice of the determination of disability within sixty (60) days after determination is issued and before the end of eighteen (18) months of coverage. If a second Qualifying Event occurs within this period of continuation coverage, the coverage for any affected dependent who was a Member under the Group Health Plan both at the time of the first and the second Qualifying Events may be extended up to thirty-six (36) months from the first Qualifying Event. For all other Qualifying Events, the maximum period of coverage is thirty-six (36) months. Below is a list of circumstances and the period of COBRA coverage for each circumstance.

i. Eighteen (18) months for Employees whose working hours are reduced, from full-time to part-time for instance and any dependents who also lose coverage for this reason.

ii. Eighteen (18) months for Employees who voluntarily quit work and any dependents who also lose coverage for this reason.

iii. Eighteen (18) months for Employees who are part of a layoff and any dependents who also lose coverage for this reason.

iv. Eighteen (18) months for Employees who are fired, unless the firing is due to gross misconduct, and any dependents who also lose coverage for this reason.

v. Twenty-nine (29) months for Employees and all covered dependents who are determined to be disabled under the Social Security Act during the first sixty (60) days after termination of employment or reduction of hours of employment. Notice of the Social Security Disability determination must be given to the COBRA Administrator within sixty (60) days of the determination of disability and before the end of the first eighteen (18) months of continuation of coverage.

vi. Thirty-six (36) months for Employees' widows or widowers and their dependent children.

vii. Thirty-six (36) months for legally separated or divorced husbands or wives and their dependent children.

viii. Thirty-six (36) months for dependent children who lose coverage because they no longer meet the Plan's definition of a dependent child.

ix. Thirty-six (36) months for dependents who are not eligible for Medicare when the Employee is eligible for Medicare and no longer has coverage with the Employer. This does not apply to any Employees or their dependents if the Employee voluntarily quit work. See Article V(A)(1)(g)(ii) of this section for coverage for Employees who voluntarily quit.

x. For Plans providing coverage for retired Employees and their dependents, a special rule applies for such persons who would lose coverage due to the Employer filing for Title 11 Bankruptcy (loss of coverage includes a substantial reduction of coverage within a year before or after the bankruptcy filing). Upon occurrence of such an event, retired Employees and their eligible dependents may continue their coverage under the Plan until the date of death of the retiree. If a retiree dies while on this special continued coverage, surviving dependents may elect to continue coverage for up to thirty-six (36) additional months.

2. USERRA

a. In any case in which an Employee or any of such Employee’s dependents has coverage under the Plan of Benefits and such Employee is not actively at work by reason of active duty service in the uniformed services, the Employee may elect to continue coverage under the Plan of Benefits as provided in this Article V(A)(2). The maximum period of coverage of the Employee and such Employee’s dependents under such an election shall be the lesser of:

i. The twenty-four (24) month period beginning on the date on which the Employee’s absence from being actively at work by reason of active duty service in the uniformed services begins; or,

ii. The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under USERRA.

The continuation of coverage period under USERRA will be counted toward any continuation of coverage period available under COBRA.

b. An Employee who elects to continue coverage under this section of this Plan of Benefits must pay one hundred and two percent (102%) such Employee's normal premium. Except that, in the case of an Employee who performs service in the uniformed services for less than thirty-one (31) days, such Employee will pay the normal contribution for the thirty-one (31) days.

c. An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Group Health Plan upon re-employment. Except as otherwise provided in this Article upon re-employment and reinstatement of coverage no new exclusion or probationary period will be imposed in connection with the reinstatement of such coverage if an exclusion would normally have been imposed. This Article applies to the Employee who is re-employed and to a dependent who is eligible for coverage under this Plan of Benefits by reason of the reinstatement of the coverage of such Employee.

d. The Article V(A)(2)(c) shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

B. QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Group Health Plan shall pay Covered Expenses in accordance with the applicable requirements of any Qualified Medical Child Support Order.

1. Procedural Requirements

   a. Timely Notifications and Determinations

      In the case of any Medical Child Support Order received by the Group Health Plan:

      i. The Employer shall promptly notify the Employee and each Alternate Recipient of the receipt of the Medical Child Support Order and the Employer's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders; and,

      ii. Within a reasonable period after receipt of such Qualified Medical Child Support Order, the Employer shall determine whether such order is a Qualified Medical Child Support Order and notify the Employee and each Alternate Recipient of such determination.

   b. Establishment of Procedures for Determining Qualified Status of Orders

      The Employer shall establish reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of Covered Expenses under such qualified orders. The Employer's procedures:

      i. Shall be in writing;

      ii. Shall provide for the notification of each person specified in a Medical Child Support Order as eligible to receive Benefits under the Plan of Benefits (at the address included in the Medical Child Support Order) of the Employer's procedures promptly upon receipt by the Plan Administrator of the Medical Child Support Order; and,

      iii. Shall permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

c. Actions Taken by Fiduciaries

If a fiduciary for the Group Health Plan acts in accordance with these procedural requirements in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the Group Health Plan obligation to the Member and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

2. Treatment of Alternate Recipients

a. Under ERISA

A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a beneficiary under the Group Health Plan for purposes of any provisions of ERISA, as amended, and shall be treated as a participant under the reporting and disclosure requirements of ERISA.

b. Direct Provision of Benefits Provided to Alternate Recipients

Any payment for Covered Expenses made by the Group Health Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

c. Plan Enrollment and Payroll Deductions

If an Employee remains covered under the Group Health Plan but fails to enroll an Alternate Recipient under the Plan of Benefits after receiving notice of the Qualified Medical Child Support Order from the Employer, the Employer shall enroll the Alternate Recipient and deduct the additional premium from the Employee's paycheck.

d. Termination of Coverage

Except for any coverage continuation rights otherwise available under the Group Health Plan, the coverage for the Alternate Recipient shall end on the earliest of:

i. The date the Employee's coverage ends;

ii. The date the Qualified Medical Child Support Order is no longer in effect;

iii. The date the Employee obtains other comparable health coverage through another insurer or Plan to cover the Alternate Recipient; or,

iv. The date the Employer eliminates family health coverage for all of its Employees.

ARTICLE VI – SUBROGATION AND REIMBURSEMENT

A. BENEFITS SUBJECT TO THIS PROVISION

This provision shall apply to all Benefits provided under any section of the Plan of Benefits. All Benefits under this Plan of Benefits are being provided by a self-funded ERISA plan.

B. STATEMENT OF PURPOSE

Subrogation and Reimbursement represent significant Group Health Plan assets and are vital to the financial stability of the Group Health Plan. Subrogation and Reimbursement recoveries are used to pay future claims by other Group Health Plan members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of the Group Health Plan. The Group Health Plan has a fiduciary obligation under the Employee Retirement Income Security Act (ERISA) to pursue and recover these Group Health Plan assets to the fullest extent possible.

C. DEFINITIONS

1. Another Party

   Another Party shall mean any individual or entity, other than this Group Health Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Member's injuries or illness.

   Another Party shall include the party or parties who caused the injuries or illness; the liability insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Member's own insurance coverage, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other insurer; a workers' compensation insurer or governmental entity; or, any other individual, corporation, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

2. Member

   As it relates to the Subrogation and Reimbursement Provision, a Member shall mean any person, dependent or representatives, other than the Group Health Plan, who is bound by the terms of the Subrogation and Reimbursement Provision herein. A Member shall include but is not limited to any beneficiary, dependent, spouse or person who has or will receive Benefits under the Group Health Plan, and any legal or personal representatives of that person, including parents, guardians, attorneys, trustees, administrators or executors of an estate of a Member, and heirs of the estate.

3. Recovery

   Recovery shall mean any and all monies identified, paid or payable to the Member through or from Another Party by way of judgment, award, settlement, covenant, release or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. A Recovery exists as soon as any fund is identified as compensation for a Member from Another Party. Any recovery shall be deemed to apply, first, for Reimbursement of the Group Health Plan's lien. The amount owed from the Recovery as Reimbursement of the Group Health Plan's lien is an asset of the Group Health Plan.

4. Reimbursement

   Reimbursement shall mean repayment to the Group Health Plan of recovered medical or other Benefits that it has paid toward care and treatment of the injuries or illness for which there has been a Recovery.

5. Subrogation

   Subrogation shall mean the Group Health Plan's right to pursue the Member's claims for medical or other charges paid by the Group Health Plan against Another Party.

D. WHEN THIS PROVISION APPLIES

This provision applies when a Member incurs medical or other charges related to injuries or illness caused in part or in whole by the act or omission of the Member or another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness; or Another Party may otherwise make a payment without an admission of liability. If so, the Member may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Member agrees, as a condition of receiving Benefits from the Group Health Plan, to transfer to the Group Health Plan all rights to recover damages in full for such Benefits.

E. DUTIES OF THE MEMBER

The Member will execute and deliver all required instruments and papers provided by the Group Health Plan or Corporation, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Group Health Plan's rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Group Health Plan for the injuries or illness. The Group Health Plan or Corporation may determine, in its sole discretion, that it is in the Group Health Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Group Health Plan will remain entitled to Subrogation and Reimbursement. In addition, the Member will do nothing to prejudice the Group Health Plan's right to Subrogation and Reimbursement and acknowledges that the Group Health Plan precludes operation of the made-whole and common-fund doctrines. A Member who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the portion of the Recovery subject to the Group Health Plan's lien to the Group Health Plan under the terms of this provision. A Member who receives any such Recovery and does not immediately tender the Group Health Plan's portion of the Recovery to the Group Health Plan will be deemed to hold the Group Health Plan's portion of the Recovery in constructive trust for the Group Health Plan, because the Member is not the rightful owner of the Group Health Plan's portion of the Recovery and should not be in possession of the Recovery until the Group Health Plan has been fully reimbursed. The portion of the Recovery owed by the Member for the Group Health Plan's lien is an asset of the Group Health Plan.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Group Health Plan or Corporation of an injury or illness for which Another Party may be liable, legally responsible or otherwise makes a payment in connection with the injuries or illness;

2. Execute and deliver to the Corporation an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

3. Deliver to the Group Health Plan or Corporation a copy of the Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;

4. Deliver to the Group Health Plan or Corporation a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so;

5. Authorize the Group Health Plan or Corporation to sue, compromise and settle in the Member's name to the extent of the amount of medical or other Benefits paid for the injuries or illness under the Group Health Plan and the expenses incurred by the Group Health Plan or Corporation in collecting this amount, and assign to the Group Health Plan the Member's rights to Recovery when this provision applies;

6. Include the amount paid for Benefits as a part of the damages sought against Another Party. Immediately reimburse the Group Health Plan or Corporation, out of any Recovery made from Another Party, the amount of medical or other Benefits paid for the injuries or illness by the Group Health Plan up to the amount of the Recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

7. Immediately notify the Group Health Plan or Corporation in writing of any proposed settlement and obtain the Group Health Plan or Corporation's written consent before signing any release or agreeing to any settlement; and,

8. Cooperate fully with the Group Health Plan or Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Group Health Plan or Corporation.

F. FIRST PRIORITY RIGHT OF SUBROGATION AND/OR REIMBURSEMENT

Any amounts recovered will be subject to Subrogation or Reimbursement. The Member's submission of claims for illnesses or injury caused by Another Party constitutes the Member's agreement to the terms of this provision and the Member's grant to the Group Health Plan of a first priority equitable lien by agreement. The Group Health Plan's right to recover exists regardless of whether it is based on Subrogation or Reimbursement.

The Group Health Plan will be subrogated to all rights the Member may have against that other person or Another Party and will be entitled to first priority Reimbursement out of any Recovery to the extent of the Group Health Plan's payments. In addition, the Group Health Plan shall have a first priority equitable lien against any Recovery to the extent of Benefits paid and to be payable in the future. The Group Health Plan's first priority equitable lien supersedes any right that the Member may have to be "made whole." In other words, the Group Health Plan is entitled to the right of first Reimbursement out of any Recovery the Member procures or may be entitled to procure regardless of whether the Member has received full compensation for any of the Member's damages or expenses, including attorneys' fees or costs and regardless of whether the Recovery is designated as payment for medical expenses or otherwise. Additionally**,** the Group Health Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative or contributory negligence, limits of collectability or responsibility, characterization of Recovery as pain and suffering or otherwise. As a condition to receiving Benefits under the Group Health Plan and Plan of Benefits, the Member agrees that acceptance of Benefits is constructive notice of this provision.

G. WHEN A MEMBER RETAINS AN ATTORNEY

An attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) for an injury or illness in which the Group Health Plan has paid or will pay Benefits, has an absolute obligation to immediately tender the portion of the Recovery subject to the Group Health Plan's equitable lien to the Group Health Plan under the terms of this provision. As a possessor of a portion of the Recovery, the Member's attorney holds the Recovery as a constructive trustee and fiduciary and is obligated to tender the Group Health Plan's portion of the Recovery immediately over to the Group Health Plan. A Member's attorney who receives any such Recovery and does not immediately tender the Group Health Plan's portion of the Recovery to the Group Health Plan will be deemed to hold the Recovery in constructive trust for the Group Health Plan, because neither the Member nor the attorney is the rightful owner of the portion of the Recovery subject to the Group Health Plan's lien. The portion of the Recovery owed for the Group Health Plan's lien is an asset of the Group Health Plan.

If the Member retains an attorney, the Member's attorney must recognize and consent to the fact that this provision precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine against the Group Health Plan in such attorney's pursuit of Recovery. The Group Health Plan will not pay the Member's attorneys' fees and costs associated with the recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Member's attorneys' fees and costs, without the expressed written consent of the Corporation.

H. WHEN THE MEMBER IS A MINOR OR IS DECEASED OR INCAPACITATED

This Subrogation and Reimbursement Provision will apply with equal force to the parents, trustees, guardians, administrators, or other representatives of a minor, incapacitated, or deceased Member and to the heirs or personal and legal representatives, regardless of applicable law. No representative of a Member listed herein may allow proceeds from a Recovery to be allocated in a way that reduces or minimizes the Group Health Plan's claim by arranging for others to receive proceeds of any judgment, award, settlement, covenant, release or other payment or releasing any claim in whole or in part without full compensation therefore or without the prior written consent from the Group Health Plan or Corporation.

I. WHEN A MEMBER DOES NOT COMPLY

When a Member does not comply with the provisions of this section, the Group Health Plan or Corporation shall have the authority, in its sole discretion, to deny payment of any claims for Benefits by the Member and to deny or reduce future Benefits payable (including payment of future Benefits for other injuries or illnesses) under the Plan of Benefits by the amount due as satisfaction for the Reimbursement to the Group Health Plan. The Group Health Plan or Corporation may also, in its sole discretion, deny or reduce future Benefits (including future Benefits for other injuries or illnesses) for the Member under any other group benefits plan maintained by the Employer. The reductions will equal the amount of the required Reimbursement; however, under no circumstances shall the Reimbursement, denial or reduction of Benefits exceed the amount of the Recovery. If the Group Health Plan must bring an action against a Member to enforce the provisions of this section, then the Member agrees to pay the Group Health Plan's attorneys' fees and costs, regardless of the action's outcome.

J. PRIOR RECOVERIES

In certain circumstances, a Member may receive a Recovery that exceeds the amount of the Group Health Plan's payments for past and/or present expenses for treatment of the injuries or illness that is the subject of the Recovery. In other situations, based on the extent of the Member's injuries or illness, the Member may have received a prior Recovery for treatment of the injuries or illness that is the subject of a claim for Benefits under the Group Health Plan. In these situations, the Group Health Plan will not provide Benefits for any expenses related to the injuries or illness for which compensation was provided through a current or previous Recovery. The Member is required to submit full and complete documentation of any such Recovery in order for the Group Health Plan to consider eligible expenses. To the extent a Member's Recovery exceeds the amount of the Group Health Plan's lien, the Group Health Plan is entitled to deny that amount as an offset against any claims for future Benefits relating to the injuries or illness. In those situations, the Member will be solely responsible for payment of medical bills related to the injuries or illness. The Group Health Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

The Group Health Plan or Corporation has sole discretion to determine whether expenses are related to the injuries or illness to the extent this provision applies. Acceptance of Benefits under this Plan of Benefits for injuries or illness which the Member has already received a Recovery may be considered fraud, and the Member will be subject to any sanctions determined by the Group Health Plan or Corporation, in their sole discretion, to be appropriate, including denial of present or future Benefits under this Plan of Benefits.

ARTICLE VII - WORKERS' COMPENSATION PROVISION

This Plan of Benefits does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member. Benefits will not be provided under this Plan of Benefits if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member or the Employer elected exemption from available workers' compensation coverage; waived entitlement to workers' compensation benefits for which the Member is eligible; failed to timely file a claim for workers' compensation benefits; or the Member sought treatment for the injury or illness from a Provider not authorized by the Member's Employer or Workers' Compensation carrier.

Although treatment for work-related or alleged work-related injuries or illness is excluded under this Plan of Benefits, the Group Health Plan or Corporation may, in its sole discretion, agree to extend coverage to a Member for the injury or illness. In this instance, the Member agrees, as a condition of receiving Benefits, to reimburse the Group Health Plan in full from any workers' compensation recovery as described herein. The Member further agrees as a condition of receiving Benefits, to execute and deliver all required instruments and papers provided by the Group Health Plan or Corporation, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Group Health Plan's right of recovery, before any medical or other Benefits will be paid by the Group Health Plan for the injuries or illness. The Group Health Plan or Corporation may determine, in its sole discretion, that it is in the Group Health Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Group Health Plan will remain entitled to reimbursement from any workers' compensation recovery the Member may receive.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Group Health Plan or Corporation of an injury or illness for which the Member's Employer and/or Employers' Workers' Compensation carrier may be liable, legally responsible or otherwise makes a payment in connection with the injuries or illness;

2. Execute and deliver to the Corporation an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

3. Deliver to the Group Health Plan or Corporation a copy of the police report, incident or accident report or any other reports issued as a result of the injury or illness within ninety (90) days of being requested to do so;

4. Assert a claim or lawsuit against the Employer and/or Employer's Workers' Compensation carrier or any other insurance coverage to which the Member may be entitled;

5. Include the amount paid for as a part of the damages sought against the Member's Employer and/or Employer's Workers' Compensation carrier. Immediately reimburse the Group Health Plan, out of any recovery made from the Employer and/or Employer's Workers' Compensation carrier, the amount of medical or other Benefits paid for the injuries or illness by the Group Health Plan up to the amount of the recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

6. Immediately notify the Group Health Plan or Corporation in writing of any proposed settlement and obtain the Group Health Plan or Corporation's written consent before signing any release or agreeing to any settlement; and,

7. Cooperate fully with the Group Health Plan or Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Group Health Plan or Corporation.

The Group Health Plan or Corporation has sole discretion to determine whether claims for Benefits submitted under the Plan of Benefits are related to the injuries or illness to the extent this provision applies. If the Group Health Plan or Corporation pays Benefits for an injury or illness and the Group Health Plan or Corporation determines the Member also received a recovery from the Employer and/or Employer's Workers' Compensation carrier by means of a settlement, judgment or other payment for the same injury or illness, the Member shall reimburse the Group Health Plan from the recovery for all Benefits paid by the Group Health Plan relating to the injury or illness. However, under no circumstances shall the Member's reimbursement to the Group Health Plan exceed the amount of such recovery.

If the Member receives a recovery from the Employer and/or Employer's Workers' Compensation carrier, the Group Health Plan's right of reimbursement from the recovery will be applied even if: liability is denied, disputed or is made by means of a compromised, doubtful and disputed, clincher or other settlement; no final determination is made that the injury or illness was sustained in the course of or resulted from the Member's employment; the amount of workers' compensation benefits due to medical or healthcare is not agreed upon or defined by the Member, Employer or the Workers' Compensation carrier; or the medical or healthcare benefits are specifically excluded from the settlement or compromise.

Failure to reimburse the Group Health Plan from the recovery as required under this section will entitle the Group Health Plan or Corporation to invoke the Workers' Compensation exclusion and deny payment for all claims relating to the injury or illness.

ARTICLE VIII - CLAIMS FILING AND APPEAL PROCEDURES

A. CLAIMS FILING PROCEDURES

1. Where a Participating Provider renders services, generally the Participating Provider should either file the claim on a Member's behalf or provide an electronic means for the Member to file a claim while the Member is in the Participating Provider's office. However, the Member is responsible for ensuring that the claim is filed.

2. For Benefits not provided by a Participating Provider, the Member is responsible for filing claims with the Corporation. When filing the claims, the Member will need the following:

    a. A claim form for each Member. Members can get claim forms from a Member services representative at the telephone number indicated on the Identification Card or via the Corporation's website, https://www.MyHealthToolkitKC.com/.

    b. Itemized bills from the Provider (s). These bills should contain all the following:

        i. Provider's name and address;

        ii. Member's name and date of birth;

        iii. Member's Identification Card number;

        iv. Description and cost of each service;

        v. Date that each service took place; and,

        vi. Description of the illness or injury and diagnosis.

    c. Members must complete each claim form and attach the itemized bill(s) to it. If a Member has other insurance that already paid on the claim(s), the Member should also attach a copy of the other Plan's EOB notice.

    d. Members should make copies of all claim forms and itemized bills for the Member's records since they will not be returned. Claims should be mailed to the Corporation's address listed on the claim form.

3. Except in the absence of legal capacity, claims must be filed no later than twelve (12) months following the date services were received.

4. Receipt of a claim by the Corporation will be deemed written proof of loss and will serve as written authorization from the Member to the Corporation to obtain any medical or financial records and documents useful to the Corporation. The Corporation, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to the Corporation in support of a Member's claim will be deemed to be acting as the agent of the Member. If the Member desires to appoint an authorized representative in connection with such Member's claims, the Member should contact the Corporation for an authorized representative form.

5. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims and Concurrent Care Claims. Determinations for each type of claim will be made within the following time periods:

   a. Pre-Service Claim

      i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.

      ii. If a Pre-service Claim is improperly filed or otherwise does not follow applicable procedures, the Member will be sent notification within five (5) days of receipt of the claim.

      iii. An extension of fifteen (15) days is permitted if the Corporation (on behalf of the Group Health Plan) determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary the Corporation will notify the Member within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference Article VIII(B) for details regarding the appeals process.

   b. Urgent Care Claim

      i. A determination will be sent to the Member in writing or in electronic form as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

      ii. If the Member's Urgent Care Claim is determined to be incomplete, the Member will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Member will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

      iii. If the Member requests an extension of urgent care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Member will be notified within twenty-four (24) hours of receipt of the request for an extension.

   c. Post-Service Claim

      i. A determination will be sent within a reasonable time period but no later than thirty (30) days from receipt of the claim.

ii. An extension of fifteen (15) days may be necessary if the Corporation (on behalf of the Group Health Plan) determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary, the Corporation will notify the Member within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference Article VIII(B) for details regarding the appeals process.

d. Concurrent Care Claim

The Member will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Member time to appeal the decision before the Benefits are reduced or terminated.

6. Notice of Determination

a. If the Member's claim is filed properly and the claim is in part or wholly denied, the Member will receive notice of an Adverse Benefit Determination, in a culturally and linguistically appropriate manner, that will:

i. Include information sufficient to identify the claim involved (including date of service, healthcare Provider, claim amount (if applicable)) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;

ii. State the specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim;

iii. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Member's claim;

iv. Reference the specific Plan of Benefits provisions on which the determination is based;

v. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;

vi. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;

vii. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA;

viii. If the reason for denial is based on a lack of Medical Necessity, Investigational or Experimental exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);

ix. Disclose any internal rule, guideline or protocol relied upon in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);

x. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals; and,

xi. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

a. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings associated with the Adverse Benefit Determination.

b. No decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.

c. The Member will also receive a notice if the claim is approved.

B. APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

1. Member has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

   a. An appeal must be in writing;

   b. An appeal must be sent (via U.S. mail) to the following address:

      BlueCross BlueShield
      P.O. Box 100121
      Columbia, South Carolina 29202

   c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,

   d. An appeal must include the Member's name, address, identification number and any other information, documentation or materials that support the Member's appeal.

2. The Member may submit written comments, documents or other information in support of the appeal and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3. The Member must raise all issues and grounds for appealing an Adverse Benefit Determination at every stage of the appeals process or such issues and grounds will be deemed permanently waived.

4. If the appealed claim involves an exercise of medical judgment, the Employer will consult with an appropriately qualified healthcare practitioner with training and experience in the relevant field of medicine. If a healthcare professional was consulted for the initial determination, a different healthcare professional will be consulted on the appeal.

5. The final decision on the appeal will be made within the time periods specified below:

    a. Pre-Service Claim

        The Corporation (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than thirty (30) days after receipt of the appeal.

    b. Urgent Care Claim

        The Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Corporation (on behalf of the Group Health Plan) will communicate with the Member by telephone or facsimile. The Corporation (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.

    c. Post-Service Claim

        The Corporation (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time but no later than sixty (60) days after receipt of the appeal.

    d. Concurrent Care Claim

        The Corporation (on behalf of the Group Health Plan) will decide the appeal of Concurrent Care Claims within the time frames set forth in Article VIII(B)(5)(a-c) depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

6. Notice of Final Internal Appeals Determination

    a. If a Member's appeal is denied in whole or in part, the Member will receive notice of an Adverse Benefit Determination, in a culturally and linguistically appropriate manner, that will:

        i. Include information sufficient to identify the claim involved (including date of service, healthcare Provider, claim amount (if applicable)) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;

        ii. State specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim and a discussion of the decision;

        iii. Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;

        iv. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;

v. Describe any voluntary appeal procedures offered by the Corporation (on behalf of the Group Health Plan) and the Member's right to obtain such information;

vi. Disclose any internal rule, guideline or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);

vii. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);

viii. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA;

ix. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals; and,

x. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act, to assist individuals with the internal claims and appeals and external review processes.

b. The Member will also receive, free of charge, any new or additional evidence considered, relied upon or generated in connection with the claim. This evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination is received to give the Member a reasonable opportunity to respond prior to that date.

c. If the Adverse Benefit Determination is based on a new or additional rationale, then the Member will be provided with the rationale, free of charge. The rationale will be provided as soon as possible and sufficiently in advance of the date of the Adverse Benefit Determination to give the Member a reasonable opportunity to respond prior to that date.

d. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings associated with the Adverse Benefit Determination.

e. No decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.

f. The Member will also receive a notice if the claim on appeal is approved.

7. The Employer has retained the Corporation to assist the Employer in making the initial claims determination as well as determinations on appeal as the claims fiduciary. Accordingly, Employer has delegated to the Corporation discretionary authority to construe and interpret questions of related to claims for Benefits under the terms of the Group Health Plan. The Employer delegates to the Corporation the discretionary authority to make utilization review and precertification determinations for the purpose of making claim decisions under the Plan of Benefits and to interpret and construe the Plan of Benefits as necessary to make such determinations. It is understood and agreed that the Corporation is a fiduciary with respect to its exercise of such discretionary authority. In making its decision, the Corporation will rely on the Plan of Benefits, its internal procedures and will rely on eligibility data provided by the Employer. The Corporation will undertake the responsibility for providing the initial and appellate review and final determination of claims that have been denied in whole or in part in accordance with the rules set forth in applicable federal law and the regulations there under.

C. EXTERNAL REVIEW PROCEDURES

1. After a Member has completed the appeal process, a Member may be entitled to an additional, external review of the Member's claim at no cost to the Member. An external review may be used to reconsider the Member's claim if the Corporation has denied, either in whole or in part, the Member's claim. In order to qualify for external review, the termination or denial or reduction of the claim must be related to:

    a. Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness of a Benefit;

    b. An Investigational or Experimental service that involves a life-threatening or seriously disabling condition; or,

    c. Administration of the Plan of Benefits' provisions related to cost-sharing and surprise billing protections for emergency or air ambulance services by Non-Participating Providers and care provided by Non-Participating Providers at certain Participating Provider facilities.

2. After a Member has completed the appeal process (and an Adverse Benefit Determination has been made), such Member will be notified in writing of such Member's right to request an external review. The Member should file a request for external review within four (4) months of receiving the notice of the Corporation's decision on the Member's appeal. In order to receive an external review, the Member will be required to authorize the release of such Member's medical records (if needed in the review for the purpose of reaching a decision on Member's claim).

3. Within five (5) business days of the date of receipt of a Member's request for an external review, the Corporation will respond by either:

    a. Assigning the Member's request for an external review to an independent review organization and forwarding the Members records to such organization; or,

    b. Notifying the Member in writing that the Member's request does not meet the requirements for an external review and the reasons for the Corporation's decision.

4. The external review organization will take action on the Member's request for an external review within forty-five (45) days after it receives the request for external review from the Corporation.

5. Expedited external reviews are available if the Member's Provider certifies that the Member has a Serious Medical Condition. A Serious Medical Condition, as used in this Article VIII(C)(5), means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place the Member's health in serious jeopardy. If the Member may be held financially responsible for the treatment, a Member may request an expedited review of the Corporation's decision if the Corporation's denial of Benefits involves Emergency Services and the Member has not been discharged from the treating Hospital. The independent review organization must make its decision within seventy-two (72) hours after it receives the request for expedited review.

ARTICLE IX - GENERAL PROVISIONS

ADMINISTRATIVE SERVICES ONLY

The Corporation provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Group Health Plan is a self-funded health Plan and the Employer assumes all financial risk and obligation with respect to claims.

AMENDMENT

Upon thirty (30) days prior written notice, the Employer may unilaterally amend the Group Health Plan. Increases in the Benefits provided or decreases in the premium are effective without such prior notice. The Corporation has no responsibility to provide individual notices to each Member when an amendment to the Group Health Plan has been made.

AUTHORIZED REPRESENTATIVES

A Provider may be considered a Member's Authorized Representative without a specific designation by the Member when the Preauthorization request is for Urgent Care Claims. A Provider may be a Member's Authorized Representative with regard to non-Urgent Care Claims only when the Member gives the Corporation or the Provider a specific designation, in a format that is reasonably acceptable to the Group Health Plan to act as an Authorized Representative. If the Member has designated an Authorized Representative, all information and notifications will be directed to that representative unless the Member gives contrary directions.

BLUECARD PROGRAM

Out-of-Area Services.

BCBSKC has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access healthcare services outside the geographic area BCBSKC serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to BCBSKC for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Agreement are described generally below.

Typically, Members, when accessing care outside the geographic area BCBSKC serves, obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from non-participating healthcare providers. BCBSKC's payment practices in both instances are described below.

A. BlueCard® Program

(a) Under the BlueCard® Program, when Members access covered healthcare services within the geographic area served by a Host Blue (a Blue Cross and /or Blue Shield Licensee other than BCBSKC), BCBSKC will remain responsible to Purchaser for fulfilling BCBSKC's contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

(b) Liability Calculation Method Per Claim.

The calculation of the Member liability on claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to BCBSKC by the Host Blue.

The calculation of the Purchaser's liability on claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSKC by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating healthcare provider(s) an inclusive allowance (e.g., per case or per day amount) for specific healthcare services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to BCBSKC by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

(iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Member and Purchaser is a final price; no future price adjustment will result in increases or decreases to the pricing of

past claims. The BlueCard Program requires that the price submitted by a Host Blue to BCBSKC is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a claim, it may also hold some portion of the amount that Purchaser pays in a variance account, pending settlement with its participating healthcare providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from Purchaser. Such payable or receivable would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices. *Some Host Blues may retain interest earned, if any, on funds held in variance accounts.*

A small number of states require Host Blues either (i) to use a basis for determining Member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge.

Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, BCBSKC would then calculate Member liability and Purchaser liability in accordance with applicable law.

(c) Return of Overpayments.

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by claim or prospective basis.

(d) BlueCard Program Fees and Compensation

Purchaser understands and agrees to reimburse BCBSKC for certain fees and compensation which BCBSKC is obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by any Purchaser. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with Purchaser's benefit period under this Agreement.

(e) BCBSKC will charge these fees as follows

Fees associated with claims processing:

- *Access fees*
- *Administrative Expense Allowance (AEA) fees*
- *Per Contract Per Month (PCPM) fees*
- *Non-Standard AEA fees*
- *Central Financial Agency (CFA) fees*
- *ITS transaction fees*

Other possible BlueCard Program-related fees:
- *Toll-free (e.g., 800 number) number fees*
- PPO provider directory fees

All BlueCard Program-related fees, including any access fees paid to Host Blues, are included in BCBSKC's Administrative Charge. See Schedule A (Fee Listing section of this Agreement).

B. Non-Participating Providers Outside BCBSKC's Service Area

For information regarding payment of a Non-Participating Provider see the "DEFINITIONS AND COVERAGE REQUIREMENTS" section of the Plan of Benefits.

Fees and Compensation

The Purchaser understands and agrees to reimburse BCBSKC for certain fees and compensation which BCBSKC is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the Programs' standard procedures for revising such fees and compensation, which do not provide for prior approval by any Purchaser. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with the Purchaser's benefit period under this Agreement.

In addition, BCBSKC must pay an administrative fee to the Host Blue, and the Purchaser further agrees to reimburse BCBSKC for any such administrative fee. See Schedule A for any applicable fees.

CLERICAL ERRORS

Clerical errors by the Corporation or the Employer will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

CONTINUATION OF CARE

If a Participating Provider's contract ends or is not renewed for any reason other than fraud or a failure to meet applicable quality standards and the Member is a Continuing Care Patient, the Member may be eligible to continue to receive in-network Benefits from that Provider with respect to the course of treatment relating to the Member's status as a Continuing Care Patient.

In order to receive this Continuation of Care, the Member must submit a request to the Corporation on the appropriate form. Upon receipt of the request, the Corporation will notify the Member and the Provider of the last date the Provider is part of the network and a summary of Continuation of Care requirements. The Corporation will review the request to determine qualification for the Continuation of Care. If additional information is necessary to make a determination, the Corporation may contact the Member or the Provider for such information. If the Corporation approves the request, in-network Benefits for that Provider will be provided, with respect to the course of treatment relating to the Member's status as a Continuing Care Patient, for ninety (90) days or until the date the Member is no longer a Continuing Care Patient for the Provider. During this time, the Provider will accept the network allowance as payment in full. Continuation of Care is subject to all other terms and conditions of this contract, including regular Benefit limits.

DISCLOSURE OF PHI TO PLAN SPONSOR

The Group Health Plan will disclose (or will require the Corporation to disclose) Member's PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Group Health Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Plan Sponsor will be subject to and consistent with the provisions of paragraphs A and B of this section.

A. Restrictions on the Plan Sponsor's Use and Disclosure of PHI.

1. The Plan Sponsor will neither use nor further disclose Member's PHI, except as permitted or required by the Group Health Plan documents, as amended, or required by law.

2. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Member PHI agrees to the restrictions and conditions of the Plan of Benefits with respect to Member's PHI.

3. The Plan Sponsor will not use or disclose Member PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

4. The Plan Sponsor will report to the Group Health Plan any use or disclosure of Member PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

5. The Plan Sponsor will make PHI available to the Member who is the subject of the information in accordance with HIPAA.

6. The Plan Sponsor will make Member PHI available for amendment and will, on notice, amend Member PHI in accordance with HIPAA.

7. The Plan Sponsor will track disclosures it may make of Member PHI so that it can make available the information required for the Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.

8. The Plan Sponsor will make its internal practices, books and records relating to its use and disclosure of Member PHI available to the Group Health Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.

9. The Plan Sponsor will, if feasible, return or destroy all Member PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Member who is the subject of the PHI, when the Member's PHI is no longer needed for the Group Health Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Plan Sponsor will limit the use or disclosure of any Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

10. The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Group Health Plan.

11. The Plan Sponsor will ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides ePHI (that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Group Health Plan) agrees to implement reasonable and appropriate security measures to protect this information.

12. The Plan Sponsor shall report any security incident of which it becomes aware to the Group Health Plan as provided below.

    a. In determining how and how often the Plan Sponsor shall report security incidents to the Group Health Plan, both the Plan Sponsor and the Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both the Plan Sponsor and the Group Health Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do not result in unauthorized access, use, disclosure, modification or destruction of ePHI or interference with an information system:

        i. Pings on a party's firewall;

        ii. Port scans;

        iii. Attempts to log on to a system or enter a database with an invalid password or username;

        iv. Denial-of-service attacks that do not result in a server being taken offline; and,

        v. Malware (e.g., worms, viruses).

    b. The Plan Sponsor shall, however, separately report to the Group Health Plan any successful unauthorized access, use, disclosure, modification or destruction of the Group Health Plan's ePHI of which the Plan Sponsor becomes aware if such security incident either (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of the Group Health Plan's ePHI; or (c) results in a breach of availability of the Group Health Plan's ePHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after the Plan Sponsor becomes aware of the impact of such security incident upon the Group Health Plan's ePHI.

B. Adequate Separation between the Plan Sponsor and the Group Health Plan.

1. Only Employees or other workforce members under the control of the Plan Sponsor (''Employees'') who, in the normal course of their duties, assist in the administration of Employee Benefits or the Group Health Plan or the Group Health Plan finances or other classes of Employees as designated in writing by the Plan Sponsor, may be given access to Member PHI received from the Group Health Plan or a business associate servicing the Group Health Plan.

2. These Employees will have access to Member PHI only to perform the Group Health Plan administration functions that the Plan Sponsor provides for the Group Health Plan.

3. These Employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Member PHI in breach or violation of or noncompliance with the provisions of this section. The Plan Sponsor will promptly report such breach, violation or noncompliance to the Group Health Plan and will cooperate with the Group Health Plan to correct the breach, violation or noncompliance to impose appropriate disciplinary action or sanctions on each Employee or other workforce member causing the breach, violation or noncompliance and to mitigate any deleterious effect of the breach, violation or noncompliance on any Member, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

4. The Plan Sponsor will ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.

The Plan Sponsor certifies that the Group Health Plan contains and that the Plan Sponsor agrees to the provisions outlined above.

EMPLOYER IS AGENT OF MEMBERS

By accepting Benefits, a Member agrees that the Employer is the Member's agent for all purposes of any notice under the Group Health Plan and Plan of Benefits. The Member further agrees that notifications received from, or given to, the Employer by the Corporation are notification to the Employees except for any notice required by law to be given to the Members by the Corporation.

GOVERNING LAW

The Group Health Plan and Plan of Benefits (including the Schedule of Benefits) are governed by and subject to applicable federal law. If and to the extent that federal law does not apply, the Group Health Plan and Plan of Benefits are governed by and subject to the laws of the State of Missouri. If federal law conflicts with any state law, then such federal law shall govern. If any provision of the Group Health Plan or Plan of Benefits conflicts with such law, the Group Health Plan and Plan of Benefits shall automatically be amended solely as required to comply with such state or federal law.

IDENTIFICATION CARD

A Member must present the Member's Identification Card prior to receiving Benefits.

Identification Cards are for identification only. Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Member whose premium has been paid. Any person receiving Covered Expenses to which the person is not entitled will be responsible for the charges.

INFORMATION AND RECORDS

The Corporation and the Employer are entitled to obtain such medical and Hospital records as may reasonably be required from any Provider incident to the treatment, payment and healthcare operations for the administration of the Benefits hereunder and the attending Provider's certification as to the Medical Necessity for care or treatment.

LEGAL ACTIONS

No Member may bring an action at law or in equity to recover under the Group Health Plan or Plan of Benefits until such Member has exhausted the appeal process as set forth in Article VIII of the Plan of Benefits. No such action may be brought after the expiration of any applicable period prescribed by law.

NEGLIGENCE OR MALPRACTICE

The Corporation and Employer do not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Member by a Provider is rendered or supplied by such Provider and not by the Corporation or the Employer. The Corporation and Employer are not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in rendering such medical treatment, service, Medical Supply or medication.

NOTICES

Except as otherwise provided in this Plan of Benefits, any notice under this Plan of Benefits may be given by United States registered or certified mail, postage paid, return receipt requested or nationally recognized carrier and addressed:

1. To the Corporation:

   BlueCross BlueShield
   P.O. Box 100121
   Columbia, South Carolina 29202

2. To a Member: To the last known name and address listed for the Employee related to such Member on the membership application. Members are responsible for notifying the Corporation of any name or address changes within thirty-one (31) days of the change.

3. To the Employer: To the name and address last given to the Corporation. The Employer is responsible for notifying the Corporation and Members of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF RIGHTS

On occasion, the Corporation (on behalf of the Group Health Plan) or the Employer may, at their discretion, choose not to enforce all of the terms and conditions of the Group Health Plan or Plan of Benefits. Such a decision does not mean the Group Health Plan or Employer waives or gives up any rights under the Group Health Plan or Plan of Benefits in the future.

OTHER INSURANCE

Each Member must provide the Group Health Plan (and its designee, including the Corporation) and Employer with information regarding all other health insurance coverage to which such Member is entitled.

PAYMENT OF CLAIMS

A Member is expressly prohibited from assigning any right to payment of or related to Benefits. The Group Health Plan may pay all Benefits directly to the Member upon receipt of due proof of loss when a Non-Participating Provider renders services. When payment is made directly to the Member, the Member is responsible for any payment to the Provider. Where a Member has received Benefits from a Participating Provider, the Group Health Plan will pay Benefits directly to such Participating Provider.

PHYSICAL EXAMINATION

The Group Health Plan has the right to have examined, at their own expense, a Member whose injury or sickness is the basis of a claim (whether a Pre-Service Claim, Post-Service Claim, Concurrent Care Claim or Urgent Care Claim). Such physical examination may be made as often as the Group Health Plan (through its designee, including the Corporation) may reasonably require while such claim for Benefits or request for Preauthorization is pending.

REPLACEMENT COVERAGE

If the Group Health Plan replaced the Employer's prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered under the Plan of Benefits Effective Date of the Group Health Plan, provided such persons are enrolled.

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Discrimination is Against the Law

Blue Cross and Blue Shield of Kansas City ("Blue KC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). Blue KC does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue KC:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact 888-495-9340.

Blue KC's Section 1557 Coordinator can be reached by contacting: Section 1557 Coordinator, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Appeals Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at Blue KC's website: https://www.bluekc.com/consumer/non-discrimination-information/

Foreign Language Access

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)

High Deductible Health Plan
Prescription Drug Plan
Summary Plan Description

Introduction

This Summary Plan Description ("SPD") describes the pharmacy benefits available under the News-Press & Gazette Company Prescription Drug Plan (the "Plan") and provides other important information, including eligibility information, covered services and exclusions, when you can make election changes, paying for coverage, and when coverage ends.

Eligibility

You are generally eligible for prescription drug coverage under the Plan if you are enrolled in coverage under the High deductible Health Plan (the "Medical Plan"). Your eligible dependents can also participate in the Plan if you elect coverage for them under the medical plan. Coverage under the Plan begins when your Medical Plan coverage begins. A covered person is referred to herein as a “Member”.

Please refer to the Medical Plan SPD for who is eligible for coverage under the Medical Plan and when coverage begins under the Medical Plan.

Cost of Coverage

Prescription drug coverage under the Plan is included in the cost of the Medical Plan you select. You and News Press & Gazette Company share in the cost of your coverage.

Mid-Year Changes

Changes you make to your medical coverage will apply to your prescription drug coverage under the Plan. Please refer to the Medical Plan SPD for the requirements for making changes during the year under the Medical Plan. Generally, you may make coverage changes during the year only if you experience a change in family status and the change in coverage is consistent with the change in status (e.g., you cover your spouse following your marriage, your child following an adoption, etc.).

The Plan is considered part of your Medical Plan under the law and, as such, the same HIPAA enrollment rights that would enable you to make enrollment changes during the year to your Medical Plan elections will apply to this Plan coverage. Please refer to your Medical Plan SPD for more details, as well as information regarding the loss or gain of eligibility under a State Children's Health Insurance Program (CHIP), Medicaid, or Medicare.

When Coverage Ends

Your coverage under the Plan will end when your coverage under the Medical Plan ends. Please refer to your Medical Plan SPD to see when your medical coverage ends.

If you lose your Medical Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA). If you elect to extend your Medical Plan coverage through COBRA, your coverage under the Plan is also extended. Please see your Medical Plan SPD for more information.

Pharmacy Benefits Overview

Prescription drug coverage for Members under the Plan is administered by Smith Health, Inc. ("SmithRx"), which is a pharmacy benefits manager ("PBM"). Benefits are provided under the Plan for prescription drugs purchased at in-network pharmacies and are subject to copayments, deductibles or other payments depending on the assigned formulary tier, as shown below. The presence of a drug on this formulary does not guarantee coverage, and the drugs listed on the formulary are subject to change.

Benefits for prescription drugs are available only when the prescription drug product meets the definition of a Covered Service under the Medical Plan. Prescription drug products that may be Covered Services consist of:

- All drugs prescribed by a physician that require a prescription either by federal or state law (including oral contraceptives).
- All compounded prescriptions containing at least one (1) prescription ingredient in a therapeutic quantity.
- Insulin and other diabetic supplies when prescribed by a physician.

Your prescription drug benefits count toward your Medical Plan deductible and out-of-pocket maximum, which are for medical and prescription drug expenses combined.

Under the Plan, you pay the full cost of your non-preventive prescription drugs until you meet the annual deductible. The amount you pay after the deductible is based on the type of drug you purchase (including its formulary tier) and whether you use a retail pharmacy, mail-order pharmacy, or specialty pharmacy, as shown below. In addition, the Plan covers certain preventive prescription drugs at 100%.

The Plan has an embedded deductible for family coverage. This means that an individual covered under the Plan has their own separate deductible, and once an individual meets their personal embedded deductible, the Plan begins to pay Plan benefits for that individual even if the family deductible has not been met. If two or more members of the family meet the family deductible, the Plan begins paying benefits for all covered members of the family, regardless of whether each Member has met the individual deductible. However, a Member may not contribute more than the individual deductible toward the family deductible.

Once your eligible combined out-of-pocket medical and prescription drug expenses (including your deductible, any coinsurance that applies, and your copays) meet the Medical Plan's out-of-pocket maximum (OOPM), the Plan will cover 100% of eligible prescription drug expenses.

The following chart summarizes the prescription drug coverage provided under the Plan. To find out if a medication you are prescribed is covered under the Plan, visit the SmithRx Member Portal

at https://portal.mysmithrx.com/login or call SmithRx at 844-454-5201 for the most current formulary information for the Plan.

<table>
<tr><th>Formulary Tier</th><th>What You Will Pay After Satisfying Deductible</th><th>Limitations, Exceptions, & Other Important Information</th></tr>
<tr><td>Generic drugs (Tier 1)</td><td>10% Coinsurance per prescription (retail);

10% Coinsurance per prescription (retail 90/mail)</td><td rowspan="5">Covers up to a 30-day supply (retail); 31-90 day supply at participating retail 90 day and mail order pharmacies (retail 90 and mail); Covers up to a 30-day supply (specialty)

You must pay the difference in cost between a Generic drug and Brand-name drug when a medical professional has not specified a Brand-name drug or has not indicated that the Brand-name drug is necessary, until the OOPM is met. Prescriptions are only covered at in-network pharmacies.</td></tr>
<tr><td>Preferred brand drugs (Tier 2)</td><td>10% Coinsurance per prescription (retail);

10% Coinsurance per prescription (retail 90/mail)</td></tr>
<tr><td>Non-preferred brand drugs (Tier 3)</td><td>10% Coinsurance per prescription (retail);

10% Coinsurance per prescription (retail 90/mail)</td></tr>
<tr><td>Specialty Preferred drugs (Tier 4)</td><td>10% Coinsurance per prescription</td></tr>
<tr><td>Specialty Non-preferred drugs (Tier 5)</td><td>10% Coinsurance per prescription</td></tr>
<tr><td colspan="3">Deductible:

In-Network $3,300 person/$6,600 family.
Out-of-Network $3,300 person/$6,600 family.

Out-of-Pocket Maximum (OOPM):

In-Network $4,000 person/$8,000 family.
Out-of-Network $8,000 person/$16,000 family.</td></tr>
</table>

When you Need to Fill a Prescription

The Plan has a network of participating pharmacies across the United States, which includes retail pharmacies (including both local, independent pharmacies and large drug store chains), mail order pharmacies that deliver prescriptions to your home, and specialty pharmacies. For home delivery, prescriptions may be filled by the pharmacy partners identified in the SmithRx Member Portal at

https://portal.mysmithrx.com/login (and currently those partners include Amazon Pharmacy, Cost Plus Drug Company, and Walmart Mail Order Pharmacy). You can obtain more information about in-network pharmacies by visiting the SmithRx Member Portal or by calling 844-454-5201.

Member Pays the Difference

Generic drugs are used to fill prescriptions whenever possible unless your provider specifies otherwise. If you are prescribed a non-preferred brand-name drug, the pharmacist may contact your provider to suggest that a non-preferred brand-name drug be substituted with a comparable drug on the Plan's formulary.

You will not be charged the difference in cost if a drug shortage for a generic product occurs. When the shortage resolves, you will be required to use the generic drug again or you will be responsible for the difference in costs.

Covered Medications

The Plan provides coverage for drugs which by law require a written prescription, as well as certain prescription supplies, oral contraceptives and some compound medications.

To be covered under the Plan, a drug or item must be prescribed by a written prescription by a licensed physician which does not exceed the accepted date range of validity. Generally, the date range of validity is one year from the date the prescription is written (six months in the case of a controlled substance). In addition, drugs covered under the Plan must be dispensed by a pharmacy and must not be listed as an exclusion under the Plan.

Prescription drugs covered by the Plan are classified in tiers of generic drugs, preferred brand name drugs (part of the Plan's formulary), non-preferred brand-name drugs (non-formulary) and specialty drugs. The Plan uses the SmithRx Essential Formulary. To find out if a medication you are prescribed is covered under the Plan, visit the SmithRx Member Portal at https://portal.mysmithrx.com/login or call 844-454-5201 for the most current formulary information.

Preventive Care Drugs

In accordance with the Affordable Care Act (ACA), the Plan covers preventive care medications on the ACA preventive drug list at 100% without any cost-sharing requirements. Preventive care includes the following as required under applicable law:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF);

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) with respect to the Member;

3. For infants and children (if coverage under the Plan are provided for them) and adolescents who are Members, evidence-informed preventive care and screenings provided for in the

comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and

4. With respect to female Members, such additional preventive care and screenings, not described in part 1, above, as are provided for in comprehensive guidelines supported by the HRSA.

New recommendations to the preventive services listed above at the schedule established by the Secretary of Health and Human Services shall be administratively updated.

You may confirm the coverage and cost-sharing for a particular drug by visiting the SmithRx Member Portal at https://portal.mysmithrx.com/login or by calling 844-454-5201 for the most current formulary information. The ACA preventive drug list is subject to change as ACA guidelines are updated or modified.

Specialty Drugs

In general, specialty drugs are high-cost medications that treat rare, complex, and chronic health conditions and may require temperature-controlled shipping or other special handling. Under the Plan, all of your specialty medications must be filled through a specialty pharmacy in the SmithRx Specialty Pharmacy Network. If you do not go through a specialty pharmacy in the SmithRx Specialty Pharmacy Network, you will pay the full cost for any specialty drugs purchased outside of the network.

For more information about specialty drugs, including a complete list of specialty prescription drug products please visit the SmithRx Member Portal at https://portal.mysmithrx.com/login or call 844-454-5201.

Prescription Drug Products from an Out-of-Network Pharmacy (Retail or Mail Order)

For prescription drug products dispensed from an out-of-network pharmacy, your reimbursement is based on the out-of-network reimbursement rate, and you are responsible for the difference between the out-of-network reimbursement rate and the out-of-network pharmacy's usual and customary charge after the applicable copayment and/or coinsurance. In most cases, you will pay more if you obtain prescription drug products from an out-of-network pharmacy.

Supply Limits

Prescription drug benefits under the Plan are subject to supply limits based on clinical and safety criteria which restrict the amount dispensed per prescription order or refill or the amount dispensed for each month's supply. For a single copayment and deductible, you may receive a prescribed medication up to the applicable supply limit. Whether or not a prescription drug has a supply limit is subject to periodic review and modification. You may confirm whether a prescription drug has been assigned a supply limit for dispensing, at the SmithRx Member Portal at https://portal.mysmithrx.com/login or by calling 844-454-5201.

SmithRx Connect Programs

SmithRx assists Members in obtaining medications through a set of programs designed to help identify the lowest net cost drugs and assist Members in navigating various cost savings programs. In some cases, SmithRx (on behalf of the Plan) may direct you to a designated pharmacy with which SmithRx has an arrangement to provide certain prescription drug products in order to obtain those drugs for you and the Plan at the lowest net cost. If you are directed to a designated pharmacy and you choose not to obtain your prescription drug product from the designated pharmacy, your medication may not be covered.

The SmithRx Connect Programs available under the Plan include:

Access Program

You are required to participate in SmithRx's Access program in order to receive coverage under the Plan for certain medications ("Access Medications"). Under the Access program, SmithRx will assist you in locating, and applying for, copayment coupons and financial assistance for Access Medications, which may allow you to receive such medications at little to no cost. However, as part of this program, certain specialty prescription drugs are considered non-essential health benefits under the Plan, and any financial assistance received through the Access program will not count toward your deductible or OOPM. (Any out-of-pocket expenses you pay (if any) in connection with obtaining an Access Medication will count toward your deductible and OOPM.) For a list of Access Medications included in the Access program, please contact SmithRx Member services. Copayments for certain Access Medications may be set to the maximum of the current Plan design or to the amount of copayment assistance available through the Access program. The Plan may cover a [60-day] grace period for urgent, "medically necessary" Access Medications to allow time to complete the Access Program application/enrollment process.

Access Plus Program

Certain high-cost specialty medications ("Access Plus Medications") are covered under the Plan only if you have first tried and failed to obtain any assistance for such medication using SmithRx's Access Plus program. Under the Access Plus program, SmithRx will assist you in applying for assistance for Access Plus Medications through advocacy foundations and grant programs to offset the cost of such drugs. For a list of Access Plus Medications, please contact SmithRx Member services. (The absence of a drug from this list does not mean the drug is covered under the Plan.) Whether you are eligible for, or are approved to receive, assistance for an Access Plus Medication under the terms and conditions of an assistance program is determined by the applicable advocacy foundation or grant program. If assistance is not available through the Access Plus program, coverage under the Plan for Access Plus Medications may be available. The Plan may also cover a [60-day] grace period for urgent, "medically necessary" Access Plus Medications to allow time to complete the Access Plus program application/enrollment process.

Cost Plus Drugs Program

SmithRx has partnered with the Mark Cuban Cost Plus Drugs Company (MCCPDC) to offer Members a lower cost for select medications through mail order from MCCPDC. Under this program, SmithRx will reach out to you via text message, email, and/or phone call if it has

identified whether substantial savings can be achieved by transferring your medication to MCCPDC. Once the medication is transferred to MCCPDC, you can place your order and have the drug delivered to your home.

Prior Authorization

For certain medications, the Plan requires a pre-service clinical review or "prior authorization" ("PA") before any benefits will be paid. There are other medications that may be covered, but with limits (for example, only for a certain amount or for certain uses), unless you receive approval through a prior authorization. The list of medications that require prior authorization will change from time to time, and drugs that do not require prior authorization may require it in the future. A current list of medications subject to prior authorization can be found on the SmithRx Member Portal at https://portal.mysmithrx.com/login. To submit a prior authorization request, you may download SmithRx's Prior Authorization Request Form at the SmithRx website at https://www.smithrx.com/member-forms/prior-authorization-request-form and work with your provider to complete the form. (The Plan has delegated to SmithRx the authority to perform clinical initial prescription drug coverage determinations, including review of prior authorization requests filed by, or on behalf of, Members.)

Step Therapy

Step therapy is a program designed to utilize the most cost-effective treatments. It requires that you try a first line alternative, often a generic medication, to treat your medical condition. Then, based on your provider's review, if necessary, you may be able to move to a brand-name drug. However, if a brand-name drug is dispensed and there is a generic available, you will pay the cost difference between the generic and the brand-name drug. Some of the drugs that require prior authorization may be subject to step therapy. A current list of medications subject to step therapy can be found on the SmithRx Member Portal at https://portal.mysmithrx.com/login.

Exclusions and Limitations

The Plan does not cover the following services, treatments or supplies, even if they are recommended or prescribed by a physician or are the only available treatment for your condition.

Excluded Drugs

The Plan does not cover certain categories of drugs or drugs prescribed under certain circumstances, including the following:

1. Drugs prescribed for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

2. Any prescription drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

3. Abortifacients

4. Alcohol swabs.

5. Allergenic extracts.

6. Anabolic steroids.

7. Anti-Obesity/Appetite Suppressants/Anorexiants

8. Blood Pressure Devices

9. Any complementary, homeopathic, alternative, or other herbal medication.

10. Contraceptives (Progestin Implants, injectables, and IUDs)

11. Cooper Contraceptives (IUD)

12. Medications used for cosmetic purposes.

13. Durable medical equipment, including insulin pumps and supplies for the management and treatment of diabetes.

14. Any fertility drugs.

15. Fluoride – oral/topical (Non-HCR)

16. Medications related to hair growth or hair reduction agents.
17. General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.

18. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of sickness or injury, except as "medically necessary" for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short-bowel syndrome, as administered under the direction of a Physician.

19. Ostomy supplies.

20. Drugs available over-the-counter (OTC).

21. Certain prescription drug products for tobacco cessation.

22. Tuberculin or other allergy syringes.

23. Any x-ray or diagnostic agent (other than COVID OTC tests).

24. Medications for which prior authorization is required, but not obtained.

Claims Review and Appeals Procedures

Under applicable Department of Labor (DOL) regulations implementing the Employee Retirement Income Security Act of 1974 (ERISA), claimants are entitled to a full and fair review of any claims made under the Plan. The procedures described in this SPD are intended to comply with ERISA and DOL regulations by providing reasonable procedures governing the filing of claims for Plan benefits, notification of benefit decisions, and appeal of adverse benefit determinations. The Plan delegates to SmithRx the authority to perform administrative and/or clinical initial prescription drug coverage determinations and appeals filed by, or on behalf of, covered Members.

Definitions

For purposes of this SPD, the following words have the following meanings:

1. A "claim" is a request for a Plan benefit made in accordance with these claims procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures. Any request for Plan benefits that is not made in accordance with these procedures is an incorrectly filed claim.

2. You become a "claimant" when you make a request for a Plan benefit in accordance with these claims procedures.

3. [Client] has been designated the "plan administrator" and "named fiduciary" under the Plan. The plan administrator may delegate any of its responsibilities to a third-party and has delegated responsibility for claims administration to SmithRx.

Types of Claims

There are three categories of claims that can be made under the Plan, each of which has somewhat different claims and appeal rules:

1. Pre-Service Claim – a claim is a pre-service claim if the benefit is conditioned, in whole or in part, on receiving approval in advance of obtaining the benefit—including any claim for benefits subject to prior authorization as described in this SPD—unless it is considered an "urgent care claim."

2. Urgent Care Claim – an urgent care claim is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise would apply to pre-service claims could seriously jeopardize the claimant's life or health or ability to regain maximum function or would – in the opinion of a physician with the knowledge of the claimant's medical condition – subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is subject to the claim.

3. Post-Service Claim – a post-service claim is any claim for a benefit under the Plan that is not a pre-service claim or an urgent care claim.

Filing a Claim

Typically, network participating pharmacies file claims for you via electronic submission to SmithRx. In very rare situations, you may need to pay for the medication up front at the pharmacy and then file a claim for reimbursement afterwards. If you believe that the pharmacy has applied the wrong cost-sharing amounts, you may pay the amount determined by the pharmacy and then submit a claim for reimbursement to SmithRx under these procedures.

To file a claim for reimbursement, you may download and complete SmithRx's claim form at the SmithRx website at https://www.smithrx.com/member-forms/member-reimbursement-form. You may also call SmithRx's Member support team at 844-454-5201 to request that the claim form be emailed to you or to ask any questions about the process. A post-service claim must be filed within 365 days following receipt of the medical service, treatment, or product to which the claim relates.

These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures. If you incorrectly file a pre-service claim (including a prior authorization request) or file a claim that is incomplete, you will be notified as soon as possible but no later than five (5) days following receipt by SmithRx of the incorrect or incomplete claim explaining that it is not a claim and describing the proper procedures for filing a claim.

An authorized representative may act on behalf of a claimant with respect to a benefit claim or appeal under these claims procedures. No person (including a treating health care professional) will be recognized as an authorized representative until the Plan receives an Appointment of Authorized Representative form signed by the claimant, except that for urgent care claims the Plan shall, even in the absence of a signed Appointment of Authorized Representative form, recognize a health care professional with knowledge of the Claimant's medical condition (e.g., the treating physician) as the Claimant's authorized representative unless the Claimant provides specific written direction otherwise.

Deciding Initial Claims

In considering and making a determination on a claim, SmithRx will consult the Plan's plan benefit design and coverage rules as documented in the Plan's Implementation Manual, as well as any applicable guidance from the IRS, the DOL, or other governmental or private publications or authorities that may assist in interpreting language or administrative procedures of the Plan.

SmithRx (on behalf of the Plan) will decide initial benefit claims on the following timeframes:

1. Pre-service claims (including standard prior authorization requests) will be determined in a reasonable time appropriate to the medical circumstances, but no later than fifteen (15) days after the receipt of the claim.

2. Urgent care claims will be decided as soon as practicable, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

3. Post-service claims will be decided within a reasonable time but no later than 30 days after receipt of the claim.

Despite the specified timeframes, nothing prevents the claimant from voluntarily agreeing to extend the above timeframes. In addition, pre-service (including standard prior authorization requests) or post-service claims may be extended for one 15-day extension due to matters beyond the plan administrator's control. The extension notice will include a description of the matters beyond the plan administrator's control that justify the extension and the date by which a decision is expected.

Notification of Benefit Decision

SmithRx (on behalf of the Plan) will provide written notification of the benefit decision to the claimant (and, in cases of prior authorization requests, to the Member's provider, as well). If the determination is an adverse decision on a claim (for example, a denial of a PA request), the information set forth in the notice will be provided in a manner calculated to be understood by the claimant (including in a culturally and linguistically appropriate manner according to applicable requirements) and will include the following:

- information sufficient to identify the claim involved, including the date of service, health care provider, and claim amount (if applicable);
- a statement of the specific reason(s) for the adverse benefit determination, including any denial code and its corresponding meaning and any Plan standard used in denying the claim;
- reference(s) to the specific Plan provision(s) on which the decision is based;
- a statement advising the claimant of the right to request diagnosis and treatment codes and their corresponding meanings;
- a description of any additional material or information necessary to perfect the claim and why such information is necessary;
- a description of the Plan procedures and time limits for appeal of the decision, external review rights, the right to obtain information about the claims procedures, and the right to sue in federal court after exhausting the Plan's claims procedures;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- if the decision involves scientific or clinical judgment, either an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided at no charge upon request;
- if the decision is based on a Plan standard (such as a medical necessity standard), a description of that standard;
- in the case of an urgent care claim, an explanation of the expedited review methods available for such Claims; and
- contact information for the DOL's Employee Benefits Security Administration and any applicable state consumer assistance program.

Notification of an adverse decision by SmithRx (on behalf of the Plan) on an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

Appeals of Adverse Benefit Determinations

The claimant will have a right to appeal a benefit determination under these claims procedures. Other than urgent care claims, an appeal of an adverse benefit determination is deemed filed when a claimant submits an Appeal Request Form to SmithRx via fax to fax number 866-642-5620.

The request for review will be treated as received by SmithRx (on behalf of the Plan) on the date that it is delivered to SmithRx at the indicated address or on the date it is deposited in the US Mail for first-class delivery in a properly stamped envelope containing the indicated name and address.

A claimant has the right to submit documents, written comments, or other information in support of an appeal. A claimant also has the right to review the claim file, and is permitted to present evidence and testimony as part of the appeals process. If SmithRx has considered, relied upon, or generated any new or additional evidence in deciding the claim, the claimant will be provided with such evidence sufficiently in advance of the due date for filing the appeal to afford the claimant an opportunity to respond to such additional evidence.

The appeal of an adverse benefit determination must be filed within 180 days following the claimant's receipt of the notification of adverse benefit decision. Failure to comply with this important deadline may cause the claimant to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

In light of the expedited timeframes for decision of urgent care claims, an urgent care appeal may be submitted to SmithRx by phone at 844-454-5201. The appeal should include the identity of the claimant, a specific medical condition or symptom, the specific treatment, service, or product for which approval or payment is requested, and any reasons why the appeal should be processed on a more expedited basis.

How Appeals Will Be Decided

SmithRx (on behalf of the Plan) will review an appeal of an adverse benefit determination. The appeal will be reviewed by a clinical team with appropriate training and experience, and will be different than the person who made the initial benefit decision and will not be a subordinate of the person who made the initial decision. The review by SmithRx's clinical team will take into account all information submitted by the claimant, whether or not presented or available at the initial benefit decision. SmithRx's clinical team will give no deference to the initial benefit decision.

A claimant shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim. SmithRx (on behalf of the Plan) will determine which information is relevant in accordance with applicable law. If the advice of a medical or vocational expert was obtained in connection with the benefit decision, the names of each such expert shall be provided on request by the claimant, regardless of whether the advice was relied upon in making the decision. SmithRx (on behalf of the Plan) will provide the

claimant, free of charge, with the rationale as soon as possible and sufficiently in advance of the final adverse benefit determination to give the claimant a reasonable opportunity to respond.

All necessary information in connection with an urgent care appeal shall be transmitted between SmithRx (on behalf of the Plan) and the claimant by phone, fax, or email.

Appeals will be decided within the following timeframes:

1. Appeals of pre-service claims (including a denial of a PA request) will be decided within a reasonable time appropriate to the medical circumstances but no later than thirty (30) days after the receipt of the request for review form.

2. Appeals of urgent care claims will be decided as soon as possible, taking into account medical exigencies, but no later than 72 hours after receipt by the Plan of the request for review.

3. Appeals of post-services claims will be decided within a reasonable time but no later than 60 days after the receipt by the Plan of the request for review form.

Notification of Decision on Appeal

Written notification of the decision on appeal shall be provided to the claimant whether or not the decision is adverse. If there is an adverse determination on appeal, notification will be written in a manner calculated to be understood by the claimant (including, if necessary, in a culturally and linguistically appropriate manner according to applicable requirements) and will include the following:

- the specific reason(s) for the appeal decision including any denial code and its corresponding meaning and any Plan standard used in denying the claim, including a discussion of the decision;

- a reference to the specific Plan provision(s) on which the decision is based;

- a statement advising the claimant of the right to request diagnosis and treatment codes and their corresponding meanings;

- a statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);

- a description of the available external review process;

- a statement of the right to sue in federal court;

- a statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination;

- if the decision involves scientific or clinical judgment, either an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided at no charge on request; and

- contact information for the DOL's Employee Benefits Security Administration and any applicable state consumer assistance program.

Notification of an adverse determination on appeal of an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

External Review

A Claimant may request external review of an adverse benefit determination by filing a request for external review within four (4) months after the date of receipt of a notice of a final adverse benefit determination. The request for external review must be made in writing to SmithRx at the address specified above.

Within five (5) business days following the date of receipt of the external review request, a preliminary review of the request will be performed to determine whether the claim is eligible for external review. Claims eligible for external review are only those that involve (a) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer; or (b) rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time). Furthermore, a claim is not eligible for external review if:

- the claimant is (or was) not covered under the Plan at the time the health care item or service is (or was) requested or, in the case of a retrospective review, the claimant was not covered under the Plan at the time the health care item or service was provided;

- the adverse benefit determination is based on the fact that the claimant was not eligible for coverage under the Plan (except where the claim relates to a rescission of coverage);

- the claimant has not exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); or

- the claimant has not provided all the information and forms required to process an external review.

The claimant will be notified of the results of the preliminary review within one business day after completion of the preliminary review. If the request is incomplete, the notice must describe the information, materials, etc. needed to complete the request, and set forth the time limit for the claimant to provide the additional information needed (the longer of the initial four-month period within which to request an external review or, if later, 48 hours (or such longer period specifically identified in the notice) after the receipt of the notice).

If the claim is eligible for external review, SmithRx (on behalf of the Plan) will assign the claim to an Independent Review Organization (IRO) to conduct the external review. (SmithRx (on behalf

of the Plan) will provide access to a panel of IROs for the purpose of obtaining an external review; SmithRx may offer the services of different IROs, or otherwise change the composition of the panel, during the plan year.)

Expedited external review may be requested when:

- an adverse benefit determination involves a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the claimant's life, health, or ability to regain maximum function, and a request for an expedited internal appeal has been filed; or

- a final internal adverse benefit determination involves (a) a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the claimant's life, health, or ability to regain maximum function; or (b) an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

The request for an expedited external review must be made in writing to SmithRx via fax to fax number 866-642-5620. Upon receipt of the request for an expedited external review, SmithRx will make a prompt determination as to whether the request meets the requirements described above for a standard external review, the claimant will be notified of the determination, and, if the request meets the requirements, an IRO will be assigned as described above for a standard external review.

External Review by IRO

The Plan will timely (in the case of an expedited external review, expeditiously) provide to the IRO documents and any information considered in making the adverse benefit determination. The claimant may submit additional information in writing to the IRO within 10 business days of the IRO's notification that it has been assigned the request for external review.

The IRO will review all of the information and documents timely received. In making its decision, the IRO is not bound by the Plan's prior determination. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

- the Claimant's medical records;

- the attending health care professional's recommendation;

- reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating health care provider;

- the terms of the Claimant's summary plan description;

- evidence-based practice guidelines;

- any applicable clinical review criteria developed and used by the Plan; and

- the opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

The IRO will provide written notice of the final external review decision to the claimant and the Plan within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision. To the extent the final external review decision reverses the Plan's decision (as was reflected in the notice of adverse benefit determination), the Plan shall follow the final external review decision of the IRO (but may initiate judicial review as described below).

In the case of an expedited external review, the IRO will provide the notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice of decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours.

Judicial Review

Upon completion of the Plan's internal review procedures or the external review procedures, either the claimant or the Plan may request judicial review of the final decision on the claim. Any action brought by, or on behalf of, a claimant for Plan benefits must be filed not later than 24 months after completion of the Plan's claims process (including, if applicable, external review).

Legally Required Notices

Please see the News-Press & Gazette Company Health & Welfare Plan plan document and summary plan description for all notices and disclosures required by applicable law including, but not limited to, the Employee Retirement Income Security Act of 1974 (ERISA), the Internal Revenue Code of 1986, COBRA, Health Insurance Portability and Accountability Act or the Affordable Care Act.