Energy Transfer LP
Health and Welfare Program for Active Employees
Medical Benefit Option
Benefit Booklet

Consumer Driven Health Plan Plus Health Savings Account (CDHP + HSA)

Preferred Provider Organization (PPO)

Effective
January 1, 2024

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SECTION I—INTRODUCTION

This booklet is a description of the Consumer Driven Health Plan Plus Health Savings Account, which is one of the medical benefit options under the Energy Transfer LP Health and Welfare Program for Active Employees (*Plan*). No oral interpretations or representations can change the written terms of the *Plan*. If there is a discrepancy between this document and the formal plan document, the terms of the plan document will prevail. For complete terms of the *Plan* and information about benefits which are not outlined in this booklet, refer to your *Plan's* wrap document, which can be obtained from your Human Resources representative. If there is any conflict between this Benefit Booklet and the *Plan's* wrap document, this Benefit Booklet will control, unless otherwise specified or required to comply with law.

The *Plan* described is designed to protect *plan participants* against certain catastrophic health expenses. This *Plan* is designed to be used with a *health savings account* (*HSA*). Terms which have special meanings when used in this *Plan* will be italicized. For a list of these terms and their meanings, please see the **Defined Terms** section of the benefit booklet. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise. Coverage under the *Plan* will take effect for an eligible *employee* and designated *dependents* when the *employee* and such *dependents* satisfy the *waiting period* and all of the eligibility requirements of the *Plan*.

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

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

Read your benefit materials carefully. Before you receive any services you need to understand which services are covered and which are excluded under your benefit *Plan*, your cost sharing obligations, and the steps you can take to minimize your out-of-pocket costs.

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

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

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

The *Plan* contains an anti-assignment provision. This provision provides that no benefit payable at any time under the *Plan* shall be subject to anticipation, alienation, sale, assignment, transfer, pledge, encumbrance, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise. Any attempt by you (or any other person, provider or entity) to do so will be void and of no effect. None of the following shall be liable for, or subject to, any obligation or liability of any *participant* (e.g., through garnishment, attachment, pledge, or bankruptcy): the *Plan*, the *Plan Administrator*, the *Claim Administrator*, or the *Company*. Benefits under the Medical Benefit Option of this *Plan* may not be assigned, transferred, or in any way made over to another party by a *participant*. This means that you may not assign to a medical provider (or to anyone) your rights to receive benefits under the *Plan*, or to bring a *claim* or lawsuit for benefits or for breach or violation of any other duty or obligation owed to you under the *Plan*. These rights are yours alone and may not be transferred to another party. No medical provider, or any other person or entity, is permitted to bring a *claim* against the *Plan* under ERISA or any other law through a purported assignment or similar agreement, and any attempt to assign or otherwise transfer such rights will be void and unenforceable. Nothing contained in the written description of the *Company's* Medical Benefit Option shall be construed to make the *Plan*, the *Company* or its affiliates liable to any third-party to whom a *participant* may be liable for medical care, treatment, or services.

A. Quick Reference Information Chart - For Help or Information

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

QUICK REFERENCE INFORMATION		
Information Needed	**Whom to Contact**	
Medical Claim Administrator • *Claim* Forms (Medical) • Medical *Claims* and Post-Service Appeals • Eligibility for Coverage • Plan Benefit Information	**AmeriBen** P.O. Box 7186 Boise, ID 83707 1-866-215-0976 **www.MyAmeriBen.com**	
Medical Management Administrator • Pre-Certification, Concurrent Review, and Case Management • Appeals of Pre-Certification	**AmeriBen Medical Management** P.O. Box 7186 Boise, ID 83707 1-800-920-7236	
Provider Network • Network Provider Directory – see website	**Blue Cross and Blue Shield of Illinois** P.O. Box 805107 Chicago, IL 60680-4112 1-800-810-BLUE (2583) **www.bcbsil.com**	
Pharmacy Benefits Manager • Retail In-Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information & Formulary • Preauthorization of Certain Drugs • Reimbursement for Out-of-Network Retail Pharmacy • Specialty Pharmacy Program • Claims and Appeals	**Retail:**	**CVS/Caremark** 1-800-837-4092 **www.caremark.com**
	Mail Order:	**CVS Caremark Mail Service Pharmacy** 1-800-837-4092 **www.caremark.com**
	Specialty:	**CVS Specialty Pharmacy** 1-800-237-2767 **www.cvsspecialty.com**
	Submit Paper Claims to: CVS/Caremark Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136 **Submit Appeals to:** CVS Caremark Prescription Claim Appeals MC 109 P.O. Box 52084 Phoenix, AZ 85072 1-866-443-1172	
Infertility Benefits (Progyny)	**Progyny** 1-833-278-1139 **https://progyny.com/find-a-provider**	
SurgeryPlus Benefits (EmployerDirect Healthcare)	**SurgeryPlus** 1-855-200-9512	
Tria Health Pharmacy Advocate Program • Diabetic Coaching Program • Smoking Cessation Program	**Tria Health** 1-888-799-8742	
HSA • HSA	**PNC Bank** 1-844-356-9993 **participant.pncbenefitplus.com/login**	
Maternal Health Program	**Baby Steps** 1-800-388-3193 **www.MyAmeriBen.com**	

SECTION II—CONSOLIDATED APPROPRIATIONS ACT OF 2021

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

A. Surprise Billing Claims

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

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

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

B. No Surprises Billing Act Requirements

Emergency Services

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

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

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

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

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

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

Non-Network Services Provided at a Network Facility

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

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

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

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

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

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

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

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

C. How Cost-Shares Are Calculated

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

D. Appeals

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

E. Transparency Requirements

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

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

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

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

1. cost sharing information that you may be responsible for, for a service from a specific *network* provider
2. a list of all *network* providers
3. cost sharing information on *non-network* provider's services what you may pay *non-network* providers for the service

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

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

F. Continuity of Care

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

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

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

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

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

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

SECTION III—MEDICAL NETWORK INFORMATION

G. In-Network and Out-of-Network Services

In-Network Provider Information

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

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

Refer to the **Consolidated Appropriations Act of 2021** section for additional provisions pertaining to Continuity of Care if an in-network provider you select terminates participation in the network while you are in active treatment.

Out-of-Network Provider Information

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

Before you obtain services or supplies from an *out-of-network* provider, you can find out whether the *Plan* will provide *in-network* or *out-of-network* benefits for those services or supplies by contacting the *Claim Administrator*.

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

The *Plan* contains an anti-assignment provision. This provision provides that no benefit payable at any time under the *Plan* shall be subject to anticipation, alienation, sale, assignment, transfer, pledge, encumbrance, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise. Any attempt by you (or any other person, provider or entity) to do so will be void and of no effect. None of the following shall be liable for, or subject to, any obligation or liability of any *participant* (e.g., through garnishment, attachment, pledge, or bankruptcy): the *Plan*, the *Plan Administrator*, the *Claim Administrator*, or the *Company*. Benefits under the Medical Benefit Option of this *Plan* may not be assigned, transferred or in any way made over to another party by a *participant*. This means that you may not assign to a medical provider (or to anyone) your rights to receive benefits under the *Plan*, or to bring a *claim* or lawsuit for benefits or for breach or violation of any other duty or obligation owed to you under the *Plan*. These rights are yours alone and may not be transferred to another party. No medical provider, or any other person or entity, is permitted to bring a *claim* against the *Plan* under ERISA or any other law through a purported assignment or similar agreement, and any attempt to assign or otherwise transfer such rights will be void and unenforceable. Nothing contained in the written description of the *Company's* Medical Benefit Option shall be construed to make the *Plan*, the *Company* or its affiliates liable to any third-party to whom a *Participant* may be liable for medical care, treatment, or services.

Provider Non-Discrimination

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

H. Choosing a Physician – Patient Protection Notice

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

You do not need prior authorization from the *Plan* or *Claim Administrator*, or from any other person (including your *PCP*) in order to obtain access to obstetrical or gynecological care from a health care professional in the *network* who specializes in obstetrics or gynecology. The health care provider, however, may be required to comply with certain procedures, including obtaining *pre-certification* for certain services, following a pre-approved treatment plan, or procedures for making referrals.

I. Special Reimbursement Provisions

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

1. **Medical Emergency.** In a *medical emergency*, a *plan participant* should try to access an *in-network* provider for treatment. However, if immediate treatment is required and access to an *in-network* provider is not possible, the services of *out-of-network* providers will be covered until the *plan participant's* condition has stabilized to the extent that they can be safely transferred to an *in-network* provider's care. At that point, if the transfer does not take place, *out-of-network* services will be covered at *out-of-network* benefit levels. *Out-of-network* charges *incurred* that meet the *medical emergency* definition will be paid based on the *maximum allowable charge*. The *plan participant* will be responsible for notifying the *Claim Administrator* for a review of any *claim* that meets this definition.
2. **No Choice of Provider.** If, while receiving treatment at an *in-network* facility and/or provider, a *plan participant* receives ancillary services or supplies from an *out-of-network* provider in a situation in which they have no control over provider selection (such as in the selection of an emergency room *physician*, an anesthesiologist, assistant surgeon, or a provider for *diagnostic services*), such *out-of-network* services or supplies will be covered at *in-network* benefit levels. *Out-of-network* charges *incurred* that meet this definition will be paid based on the *maximum allowable charge*. The *plan participant* will be responsible for notifying the *Claim Administrator* for a review of any *claim* that meets this definition.
3. **Transition of Care.** If you are currently under the care of a *non-network* provider, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a *non-network* provider may be covered at the *network* level of benefits for ninety (90) days or longer, as deemed by the *Medical Management Administrator*.

Additional information about these special reimbursement provisions, as well as a list of *in-network* providers, is available to *plan participants*, at no cost, and updated as needed, on the *Provider Network's* website. This list will include providers who specialize in obstetrics or gynecology.

Refer to the **Consolidated Appropriations Act of 2021** section for additional provisions pertaining to *balance billing/surprise billing*.

J. Network Information

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

Blue Cross and Blue Shield of Illinois

1-800-810-BLUE (2583)

www.bcbsil.com

All locations

SECTION IV—SCHEDULE OF BENEFITS

A. Verification of Eligibility: 1-866-215-0976

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

B. Schedule of Benefits

All benefits described in the Schedules of Benefits are subject to the exclusions and limitations described more fully herein, including, but not limited to, the *Claim Administrator's* determination that care and treatment is *medically necessary*; and that services, supplies, and care are not *experimental/investigational*.

This document is intended to describe the benefits provided under the *Plan,* but due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is not possible to describe all *covered charges* and/or exclusions with specificity. Please contact the *Claim Administrator* if you have questions about specific supplies, treatments, or procedures.

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

Pre-Certification

The following services must be *pre-certified*, or reimbursement from the *Plan* may be reduced:

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

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

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

   skilled nursing facility/rehabilitation facility

   inpatient mental health/*substance use disorder* treatment

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

2. chemotherapy drugs/infusions and radiation treatments (except proton beam therapy)
3. clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition
   a. This *Plan* does not cover clinical trials related to other *diseases* or conditions. Refer to the **Medical Benefits** section of this benefit booklet for a further description and limitations of this benefit.
4. dialysis
5. *durable medical equipment* in excess of $1,000 (purchase price only)
6. genetic/genomic testing, other than non-invasive pre-natal testing (NIPT)
7. *gene therapy*
8. *adoptive cell therapy* (limited to CAR T therapy)
9. *home health care services and supplies*
10. *home infusion*
11. *inpatient* and *outpatient surgery*

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

    a. office *surgeries*

b. all colonoscopies and sigmoidoscopies (screening and diagnostic)

c. elective female sterilization procedures

d. intra-articular hyaluronic acid injections

12. non-emergent air ambulance
13. orthotics/prosthetics in excess of $1,000 purchase price
14. *outpatient* imaging – Computed Tomographic (CT) studies, MRI/MRA, nuclear medicine (including SPECT scans), and PET scans (excluding services rendered in an emergency room setting)
15. *outpatient* physical therapy, occupational therapy, and speech therapy in excess of eighteen (18) visits per therapy type per *calendar year*
16. sleep studies
17. transplant, including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy

Please see the Health Care Management Program section in this benefit booklet for details.

C. Deductible Amount

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

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

Refer to the applicable Schedule of Medical Benefits for further information regarding the *deductible* amount.

D. Benefit Payment

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

Please note that the *Claim Administrator* for the *Plan* may elect to pay medical providers directly for *covered charges* for your convenience. The direct payment to a medical provider at the election of the *Claim Administrator* does not mean that the provider has any legal right to the benefits payable under the *Plan*, or the right to bring a *claim* or lawsuit for benefits under the *Plan* or for breach or violation of any other duty or obligation owed to you under the *Plan* (or ERISA or other law). As described herein, you may not assign your ERISA or other legal rights under the *Plan* to a medical provider (or any other person). In no event will the *Plan,* the *Company,* or its affiliates be liable to any third party to whom you may be liable for medical care, treatment or other services. For more information, see the Out-of-Network Provider Information subsection.

E. Out-of-Pocket Limit

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

The *out-of-pocket limit* includes applicable amounts paid for *deductibles*, *copayments*, and *coinsurance*.

Refer to the applicable Schedule of Medical Benefits for further information regarding the *out-of-pocket limit*.

F. Diagnosis-Related Grouping (DRG)

Diagnosis related grouping (*DRG*) is a method for reimbursing *hospitals* for *inpatient* services. This is when a provider bills for services that go together in a group, or bundle, instead of the individual services that make up the group separately. The provider has agreed to a set *DRG* rate with the *network*. When a service is rendered, regardless of what the provider bills, the *DRG* amount has already been set for that specific group of

services. A *DRG* amount can be higher or lower than the actual billed charge because it is based on an average cost for the services rendered.

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

- the *Plan* will base their portion of the charge on the *network allowed amount* and will not exceed the billed charges
- the *plan participant's* portion of the charge will be based on the billed charges
- the difference in the *network allowed amount* versus the actual billed charges will be the responsibility of the *Plan*

Any amount in excess of the *allowed amount* does not count toward the *Plan's* annual *out-of-pocket limit*. *Plan participants* are responsible for amounts that exceed *allowed amounts* by this *Plan*. This is known as *balance billing*.

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

G. Coinsurance

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

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

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

H. Copayments

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

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

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

I. Balance Bill

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

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

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

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

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

Refer to the **Prescription Drug Benefits** section of this benefit booklet for additional information on prescription drug coverage.

J. Consumer Driven Health Plan (CDHP)

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

How the CDHP + HSA Plan Works

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

The CDHP is paired with an optional *health savings account* (*HSA*). You may elect to make pre-tax contributions from your paycheck to your *HSA* each pay period, or you may deposit a check to your HSA at any time during the calendar year. The *CDHP* provides medical and *prescription drug* coverage, and the *HSA* provides a tax-free way to help you pay for current health expenses and to save for future health expenses in retirement. The *CDHP* gives you flexibility and discretion to determine how to use your health care benefits.

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

Applying Expenses to the Deductible

If you have not met your *deductible*, you will be responsible for 100% of the *allowed amount* for your health care expenses. If you use an *in-network* provider, the provider will submit the *claim* to the *Claim Administrator* on your behalf. If you use an *out-of-network* provider, your *physician* may ask you to pay for the services provided before you leave the office. In that case, you must submit your *claim* to the *network* to ensure your expenses are applied to the *deductible*. Refer to the Quick Reference Information Chart for contact information. You will subsequently receive an *Explanation of Benefits* from the *Claim Administrator* stating the negotiated payment amount and the amount for which you are responsible.

K. Requirements for a Health Savings Account (HSA)

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

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

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

Qualified Medical Expenses

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

L. Schedule of Medical Benefits –CDHP + HSA Option

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Deductible, per Calendar Year The *in-network* and *out-of-network deductible* amounts do not accumulate towards each other. *Co-payments* and *co-insurance* do not apply to the *deductible*.		
Per *plan participant*	$3,750	$7,500
Per *family unit*	$7,500	$15,000
Family Unit - Embedded Deductible If you are enrolled in the family option, your plan contains two (2) components: an individual *deductible* and a *family unit deductible*. Having two (2) components to the *deductible* allows for each member of your *family unit* the opportunity to have your *Plan* cover medical expenses prior to the entire dollar amount of the *family unit deductible* being met. The individual *deductible* is embedded in the family *deductible*. **For example,** if you, your spouse, and child are on a family plan with a $7,500 *family unit* embedded *deductible*, and the individual *deductible* is $3,750, and your child *incurs* $3,750 in medical bills, his/her *deductible* is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year*, even though the *family unit deductible* of $7,500 has not been met yet.		
Maximum Out-of-Pocket Limit, per Calendar Year The *out-of-pocket limit* includes *coinsurance* and *deductibles*. The *in-network* and *out-of-network out-of-pocket limits* do not accumulate towards each other.		
Per *plan participant*	$4,500	$13,500
Per *family unit*	$9,000	$27,000
Family Unit - Embedded Out-of-Pocket Limit If you are enrolled in the *family unit* option, your *Plan* contains two (2) components: an individual *out-of-pocket limit* and a *family unit out-of-pocket limit*. Having two (2) components to the *out-of-pocket limit* allows for each member of your *family unit* the opportunity to have his/her *covered charges* be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the *family unit out-of-pocket limit* being met. The individual *out-of-pocket limit* is embedded in the *family unit out-of-pocket limit*.		
The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached, at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise. **NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the *Plan*:** 1. cost containment penalties 2. amounts over the *maximum allowable charge* 3. charges not covered under the *Plan* 4. *balanced billed* charges 5. infertility, Progyny		

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

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

COVERED SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	90% after *deductible*	70% after *deductible*	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply.
Adoptive Cell Therapy	90% after *deductible*	70% after *deductible*	Limited to chimeric antigen receptor T-cell (CAR T) therapy. ***Pre-certification* is required.**
Adoptive Cell Therapy-Related Travel and Lodging Maximum	100%, *deductible* waived		**Benefit maximum:** $10,000 per *plan participant*. *Covered charges incurred* by a recipient or caregiver accumulate toward the above maximums.
Advanced Imaging	90% after *deductible*	70% after *deductible*	Includes: Computed Tomographic (CT) studies, MRI/MRA, nuclear medicine (including SPECT scans), and PET scans, excluding services rendered in an emergency room setting. ***Pre-certification* is required.**
Allergy Services			
Allergy Testing & Treatment - Performed During a PCP Office Visit	90% after *deductible*	70% after *deductible*	Services include allergy serum and injections.
Allergy Testing & Treatment - Performed During a Specialist Office Visit	90% after *deductible*	70% after *deductible*	
Allergy Testing & Treatment – Other	90% after *deductible*	70% after *deductible*	

CDHP + HSA Option

COVERED SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	SPECIAL COMMENTS
Ambulance Service	90% after *in-network deductible*		
Anesthesia	90% after *deductible*	70% after *deductible*	
Chemotherapy Drugs/Infusions and Radiation Treatments	90% after *deductible*	70% after *deductible*	This benefit applies for all covered medically necessary diagnoses. ***Pre-certification* is required for chemotherapy drugs/infusions and radiation treatments (except proton beam therapy).**
Chiropractic Treatment	90% after *deductible*	70% after *deductible*	Includes all services rendered during the visit. *Spinal manipulations* apply to the rendering provider's benefit level. **Calendar year maximum:** Twenty-six (26) visits per *plan participant*.
Diabetic Education	90% after *deductible*	70% after *deductible*	
Diagnostic Testing	90% after *deductible*	70% after *deductible*	
Durable Medical Equipment	90% after *deductible*	70% after *deductible*	***Pre-certification* is required for *DME* in excess of $1,000 purchase price.**

CDHP + HSA Option

COVERED SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	SPECIAL COMMENTS
Emergency Room			
Medical Emergency	$200 *co-payment*, then 90% after *in-network deductible*		*Out-of-network* emergency rooms are covered at the *in-network* benefit level when due to a *medical emergency*.
Non-Emergency Care	$200 *co-payment*, then 90% after *deductible*	70% after *deductible*	*Out-of-network* emergency room professional fees will be paid based on the *maximum allowable charge*.
Gene Therapy	90% after *deductible*	70% after *deductible*	
Gene Therapy-Related Travel and Lodging Maximum	100%, *deductible* waived		**Benefit maximum:** $10,000 per *plan participant*. *Covered charges incurred* by a recipient or caregiver accumulate toward the above maximums.
Genetic Testing (certain testing for prescription drugs)	90% after *deductible*	70% after *deductible*	***Pre-certification* may be required.**
Home Health Care	90% after *deductible*	70% after *deductible*	**Calendar year maximum:** One hundred (100) days per *plan participant*. Therapy provided in the home will apply to this maximum. ***Pre-certification* is required.**
Home Infusion	90% after *deductible*	70% after *deductible*	***Pre-certification* is required.**
Hospice Care	90% after *deductible*	70% after *deductible*	Services include bereavement counseling.
Inpatient Hospital			
Physician Visits	90% after *deductible*	70% after *deductible*	
Room and Board	90% after *deductible*	70% after *deductible*	Limited to the semi-private room rate. ***Pre-certification* is required.**
Injections and Infusion Therapy	90% after *deductible*	70% after *deductible*	Benefits are available for injections and infusion therapies received in a *physician's* office or other covered facility. **Note:** *specialty drugs* are separate from this benefit
Intensive Care Unit	90% after *deductible*	70% after *deductible*	Charges do not apply to the semi-private room rate. ***Pre-certification* is required.**
Lab and X-Ray			
Lab and X-Ray - Performed During a PCP Office Visit	90% after *deductible*	70% after *deductible*	
Lab and X-Ray - Performed During a Specialist Office Visit	90% after *deductible*	70% after *deductible*	
Lab and X-Ray - Other	90% after *deductible*	70% after *deductible*	

CDHP + HSA Option			
COVERED SERVICES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**SPECIAL COMMENTS**
Maternity			
Initial Office Visit	90% after *deductible*	70% after *deductible*	*Dependent* child *pregnancy* is covered. *Birthing centers* are covered as any other *inpatient* facility.
All Other Services	90% after *deductible*	70% after *deductible*	
Labor and Delivery	90% after *deductible*	70% after *deductible*	
Medical Supplies	90% after *deductible*	70% after *deductible*	**Compression stockings (Jobst):** Limited to two (2) pairs [four (4) items] per *plan participant* per *calendar year*. **Mastectomy bras and/or camisoles:** Combined limit of four (4) per *plan participant* per *calendar year*.
Office Visit			
Primary Care Physician	900% after *deductible*	70% after *deductible*	
Specialist	90% after *deductible*	70% after *deductible*	
Orthotic Appliances/Foot Orthotics/Prosthetics	90% after *deductible*	70% after *deductible*	***Pre-certification* is required for orthotics/prosthetics in excess of $1,000 purchase price.**
Outpatient Observation Stays	90% after *deductible*	70% after *deductible*	After twenty-three (23) observation hours, a confinement will be considered at this benefit level. Prior to twenty-three (23) observation hours, benefits will pay at the applicable benefit level.
Outpatient Surgery	90% after *deductible*	70% after *deductible*	***Pre-certification* is required for certain surgical procedures. Refer to Schedule of Benefits, Pre-Certification for details.**

CDHP + HSA Option			
COVERED SERVICES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**SPECIAL COMMENTS**
Routine Newborn Care	90% after *deductible*	70% after *deductible*	Routine newborn care is subject to the newborn's *deductible* and *out-of-pocket limit*. However, in circumstances limited by the *network*, the routine newborn charges will go towards the plan of the covered mother. A child born to the *dependent* of an *employee* (e.g. the *employee's* grandchild) is ineligible for coverage under the *Plan*, for services after delivery.
Skilled Nursing Facility/ Rehabilitation Facility	90% after *deductible*	70% after *deductible*	**Calendar year maximum:** Ninety (90) days per *plan participant*. Acquired brain injuries will be limited to one hundred-eighty (180) days per *plan participant*. Long term care, acute care, and rehabilitation hospital services apply toward this maximum. ***Pre-certification* is required.**
Therapy Services			
Physical Therapy Occupational Therapy Speech Therapy	90% after *deductible*	70% after *deductible*	For *inpatient* rehabilitation services, refer to the Skilled Nursing Facility/ Rehabilitation Facility row below. ***Pre-certification* is required for outpatient rehabilitation services (physical, occupational, and speech therapy) in excess of eighteen (18) visits per therapy type per calendar year.**
Urgent Care	90% after *deductible*	70% after *deductible*	
Wig(s)	90% after *deductible*		Limited to hair loss related to chemotherapy or radiation therapy. **Calendar year maximum:** $500 per *plan participant*. Includes coverage for wigs purchased over the counter.
MENTAL DISORDERS & SUBSTANCE USE DISORDER			
Inpatient	90% after *deductible*	70% after *deductible*	Includes *residential treatment facility* services. ***Pre-certification* is required.**
Outpatient	90% after *deductible*	70% after *deductible*	
Partial Hospitalization and Outpatient Intensive Day Treatment	90% after *deductible*	70% after *deductible*	***Pre-certification* is required.**

TRANSPLANTS			
Organ Transplants	90% after *deductible*	70% after *deductible*	Please refer to the **Medical Benefits** section, Covered Medical Charges, for a further description and limitations of this benefit. ***Pre-certification* is required.**
Transplant-Related Travel and Lodging Maximum	100%, *deductible* waived		**Benefit maximum:** $10,000 per transplant, per *plan participant*. *Covered charges incurred* by a recipient or caregiver accumulate toward the above maximums.

CDHP + HSA Option

COVERED SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by an *in-network* provider at a Routine Wellness Care visit if the primary reason for the appointment is *preventive care*. For more information about preventive services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**. **Safe Harbor Services:** **https://www.irs.gov/pub/irs-drop/n-04-23.pdf** **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** Non-Preventive Care services which are ordered or performed at a Routine Wellness Care visit are not considered under the Preventive Care benefit. Those services will apply to their applicable benefit level or exclusion as appropriate.			
Routine Wellness Care	100%, *deductible* waived	70% after *deductible*	Services include routine physical exam, immunizations, gynecological exam, pap smear, PSA test, colorectal cancer screening blood work, bone density testing, and shingles vaccine. Please refer to the **Medical Benefits** section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Breastfeeding Pump and Supplies	100%, *deductible* waived	Not Covered	Breastfeeding support and supplies. Over-the-counter models are included. One (1) breastfeeding pump per *pregnancy*. **Benefit maximum:** Breastfeeding pumps purchased over-the-counter are limited to $500 per *pregnancy*. The *plan participant* is responsible for submitting the *claim* to the *Claim Administrator* for reimbursement.
Colonoscopy (any diagnosis)	100%, *deductible* waived	70% after *deductible*	**Benefit maximum:** One (1) colonoscopy and related laboratory services every ten (10) years will pay at the preventive level (including ancillary charges) regardless of diagnosis. Any subsequent *claims* within the ten-year timeframe will be paid at the applicable benefit level.
Contraceptive Services	100%, *deductible* waived	70% after *deductible*	Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion. **Benefit limitations:** Services are available to all female *plan participants*.
Mammogram (any diagnosis)	100%, *deductible* waived	70% after *deductible*	**Calendar year maximum:** One (1) mammogram (includes 3D mammography) per *calendar year* will pay at the preventive level (including ancillary charges) regardless of diagnosis. Any subsequent *claims* within the *calendar-year* will be paid at the applicable benefit level.
Routine Hearing Exam	100%, *deductible* waived	70% after *deductible*	**Calendar year maximum:** Limited to one (1) routine hearing exam per *plan participant*.

CDHP + HSA Option

COVERED SERVICES	SURGERYPLUS PROVIDER	SPECIAL COMMENTS
SURGERYPLUS BENEFIT		
SurgeryPlus	90% after *deductible*	Certain tests, treatments, or other medical services may be required prior to or following a planned medical procedure with a SurgeryPlus provider. Any medical services performed by anyone other than a SurgeryPlus doctor, including pre- and post-care, shall be subject to the applicable benefit. Non-emergent spine and bariatric surgery will only be covered through SurgeryPlus. Refer to the **SurgeryPlus Benefit** section for a further description and limitations of this benefit. ***Pre-certification* may be required.**

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

M. Schedule of Prescription Drug Benefits – CDHP + HSA Option

The *prescription drug* benefits are separate from the medical benefits and are administered by CVS/Caremark, the claims and appeals fiduciary for the Prescription Drug Benefits. Refer to the **Prescription Drug Benefits** section of this plan document for additional information on prescription drug coverage.

Deductible Waiver Provision for Preventive Maintenance Prescription Drugs

No *deductible* will apply to covered preventive maintenance *prescription drug* charges for those *prescription drugs* used to treat the prevention of conditions relating to:

- asthmatic episodes
- cancer
- diabetic complications
- heart and vascular disease
- hypertension
- metabolic, nutritional and endocrine systems
- various pediatric conditions, such as fluoride deficiency or maternal and fetal problems during pregnancy

Prescription drugs purchased from an out-of-network pharmacy are not covered.

Prescription drug charges do apply to the medical deductible.

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

CVS/Caremark Retail Pharmacy Network (Up to a 30-Day Supply)	**Maintenance Choice** **CVS Caremark Mail Service Pharmacy or CVS pharmacy** (Up to a 90-Day Supply)
Generic Drugs Medical Plan *deductible* is waived, the *Plan* pays 90%.	**Generic Drugs** After you meet the Medical Plan *deductible*, the *Plan* pays90%.
Preferred Brand Name Drugs After you meet the Medical Plan *deductible*, the *Plan* pays 90%.	**Preferred Brand Name Drugs** After you meet the Medical Plan *deductible*, the *Plan* pays 90%.
Non- Preferred Brand Name Drugs After you meet the Medical Plan *deductible*, the *Plan* pays 90%.	**Non- Preferred Brand Name Drugs** After you meet the Medical Plan *deductible*, the *Plan* pays 90%.
Specialty Drugs * After you meet the *deductible*, the *Plan* pays 90%. *Specialty drugs are only available up to a thirty (30)-day supply through the Specialty Pharmacy Program. Specialty drugs are denoted with Mandatory Specialty Pharmacy Program (MSP) on the formulary drug list.	
You may receive two (2), 30-day fills for long-term medication, then you must utilize the Maintenance Choice program.	
Please Note: When a generic is available, but the *pharmacy* dispenses the brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the brand *copayment*.	
Certain *preventive care prescription drugs* [including generic contraceptives (and brand contraceptives when a generic equivalent is not available)] received by an *in-network pharmacy* are covered at 100% and the *deductible*/*copayment*/*coinsurance* (if applicable) is waived. Please refer to the following websites for information on the types of payable *preventive care prescription drugs*: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**. The *Plan* also covers certain Safe Harbor medications at the preventive rate. For a complete list of preventive and Safe Harbor medications, refer to the CVS/Caremark list at **www.caremark.com.**	

Present your *prescription drug* ID card to the *pharmacy* for *claim* processing. In certain cases, you may need to request reimbursement for prescriptions that you have filled and paid for yourself. To submit a *claim*, you must provide specific information about the prescription and the reason you are requesting reimbursement. Complete the appropriate *claim* form and mail it along with the receipt to:

CVS/Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136
1-800-837-4092
www.caremark.com

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

N. Schedule of Medical Benefits - PPO Option

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Deductible, per Calendar Year The *in-network* and *out-of-network deductible* amounts do not accumulate towards each other. *Copayments*, *co-insurance*, and *prescriptions drugs* do not apply to the *deductible*.		
Per *plan participant*	$1,250	$2,500
Per *family unit*	$3,000	$6,000
Family Unit - Embedded Deductible If you are enrolled in the family option, your plan contains two (2) components: an individual *deductible* and a *family unit deductible*. Having two (2) components to the *deductible* allows for each member of your *family unit* the opportunity to have your *Plan* cover medical expenses prior to the entire dollar amount of the *family unit deductible* being met. The individual *deductible* is embedded in the family *deductible*. **For example,** if you, your spouse, and child are on a family plan with a $2,000 *family unit* embedded *deductible*, and the individual *deductible* is $1,000, and your child *incurs* $1,000 in medical bills, his/her *deductible* is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year*, even though the *family unit deductible* of $2,000 has not been met yet.		
Maximum Out-of-Pocket Limit, per Calendar Year The *out-of-pocket limit* includes *copayments, coinsurance,* and *deductibles*. The *in-network* and *out-of-network out-of-pocket limits* do not accumulate towards each other.		
Per *plan participant*	$4,000	$8,000
Per *family unit*	$8,000	$16,000
Family Unit - Embedded Out-of-Pocket Limit If you are enrolled in the *family unit* option, your *Plan* contains two (2) components: an individual *out-of-pocket limit* and a *family unit out-of-pocket limit*. Having two (2) components to the *out-of-pocket limit* allows for each member of your *family unit* the opportunity to have his/her *covered charges* be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the *family unit out-of-pocket limit* being met. The individual *out-of-pocket limit* is embedded in the *family unit out-of-pocket limit*		
The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached, at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise. **NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the *Plan*:** 1. cost containment penalties 2. amounts over the *maximum allowable charge* 3. charges not covered under the *Plan* 4. *balanced billed* charges 5. infertility services, Progyny		

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

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

COVERED SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	80% after *deductible*	55% after *deductible*	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply.
Adoptive Cell Therapy	70% after *deductible*	55% after *deductible*	Limited to chimeric antigen receptor T-cell (CAR T) therapy. ***Pre-certification* is required.**
Adoptive Cell Therapy-Related Travel and Lodging Maximum	100%, *deductible* waived		**Benefit maximum:** $10,000 per *plan participant*. *Covered charges incurred* by a recipient or caregiver accumulate toward the above maximums.
Advanced Imaging	80% after *deductible*	55% after *deductible*	Includes: Computed Tomographic (CT) studies, MRI/MRA, nuclear medicine (including SPECT scans), and PET scans, excluding services rendered in an emergency room setting. ***Pre-certification* is required.**
Allergy Services			
Allergy Testing & Treatment - Performed During a PCP Office Visit	$25 *copayment*, *deductible* waived	55% after *deductible*	Services include allergy serum and injections.
Allergy Testing & Treatment - Performed During a Specialist Office Visit	$40 *copayment*, *deductible* waived	55% after *deductible*	
Allergy Testing & Treatment - Other	80% after *deductible*	55% after *deductible*	

PPO Option

COVERED SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	SPECIAL COMMENTS
Ambulance Service	80% after *in-network deductible*		
Anesthesia	80% after *deductible*	55% after *deductible*	
Chemotherapy Drugs/Infusions and Radiation Treatments	80% after *deductible*	55% after *deductible*	This benefit applies for all covered medically necessary diagnoses. ***Pre-certification* is required for chemotherapy drugs/infusions and radiation treatments (except proton beam therapy).**
Chiropractic Treatment	$40 *copayment*, *deductible* waived	55% after *deductible*	Include all services rendered during the visit. *Spinal manipulations* apply to the rendering provider's benefit level. **Calendar year maximum:** Twenty-six (26) visits per *plan participant*.
Diabetic Education	80% after *deductible*	55% after *deductible*	
Diagnostic Testing	80% after *deductible*	55% after *deductible*	
DNA Testing (certain testing for prescription drugs)	100%, *deductible* waived	55% after *deductible*	***Pre-certification* is required.**
Durable Medical Equipment	80% after *deductible*	55% after *deductible*	***Pre-certification* is required for *DME* in excess of $1,000 purchase price.**

PPO Option

COVERED SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	SPECIAL COMMENTS
Emergency Room			
Medical Emergency	$200 *co-payment*, then 80% after *in-network deductible*		*Out-of-network* emergency rooms are covered at the *in-network* benefit level when due to a *medical emergency*.
Non-Emergency Care	$200 *co-payment*, then 80% after *deductible*	55% after *deductible*	*Out-of-network* emergency room professional fees will be paid based on the *maximum allowable charge*.
Gene Therapy	80% after *deductible*	55% after *deductible*	
Gene Therapy-Related Travel and Lodging Maximum	100%, *deductible* waived		**Benefit maximum:** $10,000 per *plan participant*. *Covered charges incurred* by a recipient or caregiver accumulate toward the above maximums. Covered only when an approved facility is used.
Genetic Testing	80% after *deductible*	55% after *deductible*	***Pre-certification* may be required.**
Home Health Care	80% after *deductible*	55% after *deductible*	**Calendar year maximum:** One hundred (100) days per *plan participant*. Therapy provided in the home will apply to this maximum. ***Pre-certification* is required.**
Home Infusion	80% after *deductible*	55% after *deductible*	***Pre-certification* is required.**
Hospice Care	80% after *deductible*	55% after *deductible*	Service include bereavement counseling.
Injections and Infusion Therapy	80% after *deductible*	55% after *deductible*	Benefits are available for injections and infusion therapies received in a *physician's* office% or other covered facility. **Note:** *specialty drugs* are separate from this benefit
Inpatient Hospital			
Physician Visits	80% after *deductible*	55% after *deductible*	
Room and Board	80% after *deductible*	55% after *deductible*	Limited to the semi-private. ***Pre-certification* is required.**
Intensive Care Unit	80% after *deductible*	55% after *deductible*	Charges do not apply to the semi-private room rate. ***Pre-certification* is required.**

PPO Option			
COVERED SERVICES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**SPECIAL COMMENTS**
Lab and X-Ray			
Lab and X-Ray - Performed During a PCP Office Visit	$25 *copayment*, *deductible* waived	55% after *deductible*	
Lab and X-Ray - Performed During a Specialist Office Visit	$35 *copayment*, *deductible* waived	55% after *deductible*	
Lab and X-Ray - Other	80% after *deductible*	55% after *deductible*	
Maternity			
Initial Office Visit	$25 *copayment*, *deductible* waived	55% after *deductible*	*Dependent* child *pregnancy* is covered. *Copayment* on first office visit only. *Birthing centers* are covered as any other *inpatient* facility.
All Other Services	80% after *deductible*	55% after *deductible*	
Labor and Delivery	80% after *deductible*	55% after *deductible*	
Medical Supplies	80% after *deductible*	55% after *deductible*	**Compression stockings (Jobst):** Limited to two (2) pairs [four (4) items] per *plan participant* per *calendar year*. **Mastectomy bras and/or camisoles:** Combined limit of four (4) per *plan participant* per *calendar year*.
Office Visit			
Primary Care Physician	$25 *copayment*, *deductible* waived	55% after *deductible*	The office visit *copayment* will apply to the office visit including labs and x-rays performed and billed by the *physician* for the same date of service. The highest office visit *copayment* will apply. This will apply regardless of whether the *physician's* office is freestanding, located in a clinic, or located in a *hospital*.
Specialist	$40 *copayment*, *deductible* waived	55after *deductible*	
Orthotic Appliances/Foot Orthotics/Prosthetics	80% after *deductible*	55% after *deductible*	***Pre-certification* is required for orthotics/prosthetics in excess of $1,000 purchase price.**
Outpatient Observation Stays	80% after *deductible*	55% after *deductible*	After twenty-three (23) observation hours, a confinement will be considered at this benefit level. Prior to twenty-three (23) observation hours, benefits will pay at the applicable benefit level.
Outpatient Surgery	80% after *deductible*	55% after *deductible*	***Pre-certification* is required for certain surgical procedures. Refer to Schedule of Benefits, Pre-Certification for details.**

PPO Option			
COVERED SERVICES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**SPECIAL COMMENTS**
Routine Newborn Care	80% after *deductible*	55% after *deductible*	Routine newborn care is subject to the newborn's *deductible* and *out-of-pocket limit*. However, in circumstances limited by the *network*, the routine newborn charges will go towards the plan of the covered mother. A child born to the *dependent* of an *employee* (e.g. the *employee's* grandchild) is ineligible for coverage under the *Plan*, for services after delivery.
Skilled Nursing Facility/ Rehabilitation Facility	80% after *deductible*	55% after *deductible*	**Calendar year maximum:** Ninety (90) days per *plan participant*. Acquired brain injuries will be limited to one hundred-eighty (180) days per *plan participant*. Long term care, acute care, and rehabilitation hospital services apply toward this maximum. ***Pre-certification* is required.**
Therapy Services			
Physical Therapy Occupational Therapy Speech Therapy	80% after *deductible*	55% after *deductible*	For *inpatient* rehabilitation services, refer to the Skilled Nursing Facility/ Rehabilitation Facility row below. ***Pre-certification* is required for outpatient rehabilitation services (physical, occupational, and speech therapy) in excess of eighteen (18) visits per therapy type per calendar year.**
Urgent Care	$50 *copayment*, *deductible* waived	55% after *deductible*	The urgent care visit *copayment* will apply to the urgent care visit including labs and x-rays performed and billed by the *physician* for the same date of service.
Wig(s)	100% after *deductible*		Limited to hair loss related to chemotherapy or radiation therapy. **Calendar year maximum:** $500 per *plan participant*. Includes coverage for wigs purchased over the counter.

PPO Option			
COVERED SERVICES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**	**SPECIAL COMMENTS**
MENTAL DISORDERS & SUBSTANCE USE DISORDER			
Inpatient	80% after *deductible*	55% after *deductible*	Includes *residential treatment facility* services. ***Pre-certification* is required.**
Outpatient - PCP	$25 *copayment*, *deductible* waived	55% after *deductible*	
Outpatient - Specialist	$40 *copayment*, *deductible* waived	55% after *deductible*	
Partial Hospitalization and Outpatient Intensive Day Treatment	$25 *copayment*, *deductible* waived	55% after *deductible*	***Pre-certification* is required.**
TRANSPLANTS			
Organ Transplants	80% after *deductible*	55% after *deductible*	Please refer to the **Medical Benefits** section, Covered Medical Charges, for a further description and limitations of this benefit. ***Pre-certification* is required.**
Transplant-Related Travel and Lodging Maximum	100%, *deductible* waived		**Benefit maximum:** $10,000 per transplant, per *plan participant*. *Covered charges incurred* by a recipient or caregiver accumulate toward the above maximums.

PPO Option

COVERED SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by an *in-network* provider at a Routine Wellness Care visit if the primary reason for the appointment is *preventive care*. For more information about preventive services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations** **Safe Harbor Services:** **https://www.irs.gov/pub/irs-drop/n-04-23.pdf** **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** Non-Preventive Care services which are ordered or performed at a Routine Wellness Care visit are not considered under the Preventive Care benefit. Those services will apply to their applicable benefit level or exclusion as appropriate.			
Routine Wellness Care	100%, *deductible* waived	55% after *deductible*	Services include routine physical exam, immunizations, gynecological exam, pap smear, PSA test, colorectal cancer screening blood work, bone density testing, and shingles vaccine. Please refer to the **Medical Benefits** section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Breastfeeding Pump and Supplies	100%, *deductible* waived	55% after *deductible*	Breastfeeding support and supplies. Over-the-counter models are included. One (1) breastfeeding pump per *pregnancy*. **Benefit maximum:** Breastfeeding pumps purchased over-the-counter are limited to $500 per *pregnancy*. The *plan participant* is responsible for submitting the *claim* to the *Claim Administrator* for reimbursement.
Colonoscopy (any diagnosis)	100%, *deductible* waived	55% after *deductible*	**Benefit maximum:** One (1) colonoscopy and related laboratory services every ten (10) years will pay at the preventive level (including ancillary charges) regardless of diagnosis. Any subsequent *claims* within the ten-year timeframe will be paid at the applicable benefit level.
Contraceptive Services	100%, *deductible* waived	55% after *deductible*	Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion. **Benefit limitations:** Services are available to all female *plan participants*.
Mammogram (any diagnosis)	100%, *deductible* waived	55% after *deductible*	**Calendar year maximum:** One (1) mammogram (includes 3D mammography) per calendar year will pay at the preventive level (including ancillary charges) regardless of diagnosis. Any subsequent *claims* within the *calendar-year* will be paid at the applicable benefit level.
Routine Hearing Exam	100%, *deductible* waived	55% after *deductible*	**Calendar year maximum:** Limited to one (1) routine hearing exam per *plan participant*.

PPO Option

COVERED SERVICES	SURGERYPLUS PROVIDER	SPECIAL COMMENTS
SURGERYPLUS BENEFITS		
SurgeryPlus	100% after *deductible*	Certain tests, treatments, or other medical services may be required prior to or following a planned medical procedure with a SurgeryPlus provider. Any medical services performed by anyone other than a SurgeryPlus doctor, including pre- and post-care, shall be subject to the terms of the applicable benefit. Non-emergent spine and bariatric surgery will only be covered through SurgeryPlus. Refer to the **SurgeryPlus Benefit** section for a further description and limitations of this benefit. ***Pre-certification* may be required.**

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

O. Schedule of Prescription Drug Benefits – PPO Option

The *prescription drug* benefits are separate from the medical benefits and are administered by CVS/Caremark, the claims and appeals fiduciary for the Prescription Drug Benefits. Refer to the **Prescription Drug Benefits** section of this plan document for additional information on prescription drug coverage.

Prescription drugs purchased from an out-of-network pharmacy are not covered.

Prescription drug charges do not apply to the medical deductible.

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

Deductible, per Calendar Year	
Per *plan participant*	$150
Per *family unit*	$300
CVS/Caremark Retail Pharmacy Network (Up to a 30-Day Supply)	**Maintenance Choice** **CVS Caremark Mail Service Pharmacy or CVS pharmacy** (Up to a 90-Day Supply)
Generic Drugs Copayment $7 *co-payment*, *deductible* waived	**Generic Drugs Copayment** $14 *co-payment*, *deductible* waived
Preferred Brand Name Drugs Copayment $40 *co-payment* after prescription drug *deductible*	**Preferred Brand Name Drugs Copayment** $80 *co-payment* after prescription drug *deductible*
Non-Preferred Brand Name Drugs Copayment $70 *co-payment* after prescription drug *deductible*	**Non- Preferred Brand Name Drugs Copayment** $140 *co-payment* after prescription drug *deductible*
Specialty Drugs Copayment* $100 *co-payment*, *deductible* waived/per generic $100 *co-payment* after prescription drug *deductible*/preferred brand name $100 *co-payment* after prescription drug *deductible*/non-preferred brand name *Specialty Drugs are only available up to a thirty (30)-day supply through the Specialty Pharmacy Program. Specialty Drugs are denoted with Mandatory Specialty Pharmacy Program (MSP) on the preferred drug list.	
You may receive two (2), 30-day fills for long-term medication, then you must utilize the Maintenance Choice program.	
Please Note: When a generic is available, but the *pharmacy* dispenses the brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the brand *copayment*.	
Certain *preventive care prescription drugs* [including generic contraceptives (and brand contraceptives when a generic equivalent is not available)] received by an *in-network pharmacy* are covered at 100% and the *deductible*/*copayment*/*coinsurance* (if applicable) is waived. Please refer to the following websites for information on the types of payable *preventive care prescription drugs*: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**. The *Plan* also covers certain Safe Harbor medications at the preventive rate. For a complete list of preventive and Safe Harbor medications, refer to the CVS/Caremark list at **www.caremark.com.**	

Present your *prescription drug* ID card to the *pharmacy* for *claim* processing. In certain cases, you may need to request reimbursement for prescriptions that you have filled and paid for yourself. To submit a *claim*, you must provide specific information about the prescription and the reason you are requesting reimbursement. Complete the appropriate *claim* form and mail it along with the receipt to:

CVS/Caremark
P.O. Box 52136f
Phoenix, AZ 85072-2136
1-800-837-4092
www.caremark.com

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

P. Schedule of Outpatient Dialysis Services

The *outpatient* dialysis benefits are considered under the following benefit structure. Refer to the **Outpatient Dialysis Services** section of this plan document for additional information on outpatient dialysis services coverage.

COVERED SERVICES	ALL PROVIDERS	SPECIAL COMMENTS
DIALYSIS, OUTPATIENT		
CDHP + HSA	90% after *deductible*	The following *outpatient dialysis* services will be considered at 140% of *Medicare*, and then *Plan* benefits will apply. • facility and professional charges from *outpatient hospitals* and dialysis facilities • home dialysis charges Refer to the **Outpatient Dialysis Services** section for a further description and limitations of this benefit. ***Pre-certification* is required.**
PPO Option	80% after *deductible*	

Q. Schedule of Infertility Benefits, Progyny

The *infertility* benefits under the Plan are separate from the medical benefits and are administered by Progyny. Refer to the Infertility Benefits, Progyny section of this plan document for additional information on *infertility* benefits coverage.

COVERED SERVICES	PROGYNY PROVIDERS	SPECIAL COMMENTS
INFERTILITY SERVICES		
Deductible, per Calendar Year: $4,000 *Copayments* and *co-insurance* do not apply to the *deductible*.		
Maximum Out-of-Pocket Limit, per Calendar Year: $8,000 The *out-of-pocket limit* includes the *deductible* and *coinsurance*.		
Progyny SMART Cycle	80% after *deductible*	Two (2) consultations per plan year. Two (2) Smart Cycles per lifetime, subject to all applicable plan benefits. ***Pre-certification* is required.**
Surrogacy/Donor	80% after *deductible*	$10,000 per child reimbursement. Services may not be covered by another source to qualify for reimbursement. ***Pre-certification* is required.**

SECTION V—MEDICAL BENEFITS

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

A. Covered Medical Charges

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

1. **3D Mammogram.**
2. **Applied Behavioral Analysis Therapy (ABA).**
3. **Acquired Brain Injury Treatment.** Benefits for *covered charges incurred* for *medically necessary* treatment of an *acquired brain injury* will be determined on the same basis as treatment for any other physical condition. *Covered charges* include the following services as a result of and related to an *acquired brain injury*:
    a. **Cognitive communication therapy:** Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
    b. **Cognitive rehabilitation therapy:** Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.
    c. **Community reintegration services:** Services that facilitate the continuum of care as an affected individual transitions into the community;
    d. **Neurobehavioral testing:** An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
    e. **Neurobehavioral treatment:** Interventions that focus on behavior and the variables that control behavior.
    f. **Neurocognitive rehabilitation:** Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
    g. **Neurocognitive therapy:** Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
    h. **Neurofeedback therapy:** Services that utilizes operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
    i. **Neurophysiological testing:** An evaluation of the functions of the nervous system.
    j. **Neurophysiological treatment:** Interventions that focus on the functions of the nervous system.
    k. **Neuropsychological testing:** The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
    l. **Neuropsychological treatment:** Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
    m. **Post-acute transition services:** Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
    n. **Psychophysiological testing:** An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

o. **Psychophysiological treatment:** Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

p. **Remediation:** The process(es) of restoring or improving a specific function.

Service means the work of testing, treatment, and providing therapies to an individual with an a*cquired brain injury.*

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an *acquired brain injury*.

Benefits for *acquired brain injury* will be limited to one hundred eighty (180) days per *calendar year*, per *participant*, for Skilled Nursing Facility/Rehabilitation Facility days. This limit is reduced for any Skilled Nursing Facility/Rehabilitation Facility days utilized in the *calendar year* by the *participant* for any other reason, as applicable in the Schedule of Medical Benefits. All other benefit limits and *Plan* maximums apply as noted in the Schedule of Medical Benefits.

4. **Adoptive Cell Therapy.** Limited to FDA approved chimeric antigen receptor T-cell (CAR T) therapy, along with associated services and supplies. ***Pre-certification* is required**. Refer to the Travel and Lodging provision in the Covered Medical Charges for applicable travel benefits.
5. **Advanced Imaging.** Charges for advanced imaging including: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear medicine (including SPECT scans), and PET scans. Charges include the readings of these medical tests/scans. ***Pre-certification* is required.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
6. **Allergy Services.** Charges for allergy testing and the cost of the resultant serum preparation (antigen) and its administration, when rendered by a *physician*, or in the *physician's* office. Refer to the Medical Plan Exclusions subsection for limits to this benefit.
7. **Ambulance.** Benefits will be provided for professional ambulance services used to transport you from the place where you are *injured* or stricken by *illness* to the nearest accredited general *hospital* with adequate facilities for treatment. Inter-facility transport is also available to a *network hospital* after you have been stabilized at a *non-network hospital*. Benefits will be provided for inter-facility ambulance transport as deemed *medically necessary*. Charges for services requested for a professional ambulance service, when the patient is not transported, will be covered by the *Plan*. ***Pre-certification* is required for non-emergent air ambulance.**
8. **Anesthetics.** Includes anesthetic, oxygen, intravenous injections/solutions, and the administration of these items.
9. **Blood.** Non-replaced blood, blood plasma, blood derivatives, and their administration and processing.
10. **Cardiac Rehabilitation.** Cardiac rehabilitation as deemed *medically necessary*.
11. **Chemotherapy, Radiation Therapy, or Proton Beam Therapy.** Radiation or chemotherapy and treatment with radioactive substances, including materials and services of technicians. Also proton beam therapy treatments that are determined to be medically necessary for the treatment of cancer by the individual's treating physician. ***Pre-certification* is required for chemotherapy drugs/infusions and radiation treatments (except proton beam therapy).**
12. **Chiropractic.** All *medically necessary* services. Services are subject to the limit shown in the applicable Schedule of Medical Benefits.
13. **Circumcision.** Circumcision for newborns from birth to twenty-eight (28) days. After twenty-eight (28) days, only *medically necessary* circumcisions will be covered.
14. **Clinical Trials.** This *Plan* will cover routine patient costs for a *qualified individual* participating in an *approved clinical tria*l that is conducted in connection with the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an *investigational* new drug application reviewed by the Food and Drug Administration, or is exempt from *investigational* new drug application requirements. Refer to the Medical Plan Exclusions subsection for a further description and limitations of this benefit. ***Pre-certification* is required.**
15. **Cochlear Implants. *Pre-certification* is required for *inpatient* and *outpatient surgery*.** See *pre-certification* list for exceptions to surgical *pre-certification*.

16. **Contraceptives.** Injections, implants, devices, and associated *physician* charges are covered under the Preventive Care provision of this *Plan*. Self-administered contraceptives (not over-the-counter), are covered under the **Prescription Drug Benefits** section of this *Plan*.
17. **COVID-19 Services.** The *Plan* provides coverage for diagnostic testing (except over-the-counter) and treatment.
18. **Dental Injuries.** Charges for the correction of damage caused solely by external, violent, *accidental injury* to healthy, unrestored natural teeth and supporting tissues and limited to treatment provided within twenty-four (24) months of the initial treatment.

    An *injury* sustained as a result of biting or chewing shall not be considered an *accidental injury*.

    Any other dental services, except as excluded in the Medical Plan Exclusions subsection of this benefit booklet, for which a *plan participant incurs inpatient hospital* expenses for a *medically necessary inpatient hospital admission*, will be determined as described in the Hospital provision.
19. **Diabetic Education.** Services and supplies used in *outpatient* diabetes self-management programs are covered under this *Plan* when they are provided by a *physician*. This is separate from nutritional counseling. Refer to the Nutritional Counseling provision for more information.
20. **Diabetic Equipment.** Benefits are available for the following:
    a. blood glucose monitors (including noninvasive glucose monitors and monitors for the blind)
    b. insulin pumps (both external and implantable) and associated appurtenances, which include:
        i. insulin infusion devices
        ii. batteries
        iii. skin preparation items
        iv. adhesive supplies
        v. infusion sets
        vi. insulin cartridges
        vii. durable and disposable devices to assist in the injection of insulin
        viii. other required disposable supplies
    c. Podiatric appliances, including up to two (2) pairs of therapeutic footwear per *calendar year*, for the prevention of complications associated with diabetes.

    Refer to the *Preventive Care* provision or visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of diabetic equipment and supplies related *preventive care* benefits.

    For all other diabetic supplies coverage, refer to the **Prescription Drugs Benefits** section.
21. **Diagnostic Testing.**
22. **Durable Medical Equipment.** Rental of *durable medical equipment* (*DME*) if deemed *medically necessary*. The total rental fee for *durable medical equipment* will not exceed the purchase price of the equipment. If the purchase price is not available, rental is allowed for the *lifetime* of the equipment. Delivery or set-up charges are not a benefit of the *Plan*. Education pertaining to the use of *DME* is covered.

    ***Pre-certification* is required when the purchase price is expected to exceed $1,000.**

    Replacement of purchased equipment is covered if either:

    a. the replacement is needed because of a change in your physical condition
    b. it is likely to cost less to replace the item than to repair the existing item or rent a similar item

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

    The following item will be considered under the *DME* benefit:

    a. **Oxygen.** Oxygen and its administration, including oxygen concentrators. Oxygen concentrators are not subject to purchase price requirements.
    b. **Sleep apnea oral devices.**

23. **Foot Care.** Foot care in connection with an *illness*, *disease*, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes. Foot orthotics are covered for treatment of diabetes, circulatory disorders of lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency. There is no *calendar year* maximum. This is in addition to, and does not affect the coverage for podiatric appliances as shown under the Diabetes Equipment provision Non-custom molded foot orthotics are not covered.

24. **Genetic/Genomic Testing and Counseling.** Genetic and genomic testing to identify the potential for, or existence of, a medical condition and/or to examine abnormalities in groups of genes to aid in designing specific treatment options for an individual's condition as mandated by PPACA or as *medically necessary*. Non-invasive pre-natal testing (NIPT) is covered when *medically necessary*. ***Pre-certification*** **is required for genetic/genomic testing.**

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

25. **Gene Therapy.**

26. **Gene Therapy Travel and Lodging.** Coverage is available only at an approved facility for reimbursement of travel and lodging expenses *incurred* during gene therapy (immediately prior to and after gene therapy) for *plan participant* and one (1) family member up to the benefit maximum listed in the applicable Schedule of Medical Benefits.

    These benefits will be reimbursed upon the submission to the *Plan* of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service provider. The listed expenses must be *incurred* within five (5) days prior to gene therapy and one hundred twenty (120) days after the gene therapy. The *Plan Administrator* reserves the right not to reimburse any such expenses that it, in its sole discretion, deems inappropriate, excessive, or not in keeping with the intent of this provision.

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

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

    b. A home health care visit will be considered a periodic visit by a *physician* or appropriate health care practitioner for the services being rendered.

    Pre-certification **is required.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

28. **Home Infusion Therapy.** Home infusion therapy does not apply to the home health care maximum. ***Pre-certification*** **is required.**

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

30. **Hospice Care.** Benefits are available for home and facility based *hospice care services and supplies*. Service include:

    a. **Home hospice services.** Benefits **include:**

        i. Part-time or intermittent nursing care by a registered nurse (R.N.), advanced practice nurse (A.P.N.), or by a licensed vocational nurse (L.V.N.).

        ii. Part-time or intermittent home health aide services which consist primarily of caring for the *plan participant*.

        iii. Physical, speech, and respiratory therapy services by licensed therapists.

        iv. Homemaker and counseling services routinely provided by the hospice care agency, including bereavement counseling.

    b. **Facility hospice care.** Benefits **include:**

        i. All usual nursing care by a registered nurse (R.N.), advanced practice nurse (A.P.N.), or by a licensed vocational nurse (L.V.N.).

ii. *Room and board* and all routine services, supplies, and equipment provided by the hospice facility.

iii. Physical, speech, and respiratory therapy services by licensed therapists or a physician acting within the scope of his/her license.

c. **Bereavement counseling services.** Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the hospice patient's immediate family (covered spouse and/or other covered *dependents*).

If the deceased is not a *plan participant*, then bereavement counseling will be covered under the Mental Disorders and Substance Use disorder provision.

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

***Pre-certification* is required.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

31. **Hospital Care.** The medical services and supplies furnished by a *hospital*, *ambulatory surgical facility*, or a *birthing center*. An office visit when the provider's office is located inside a *hospital* will apply to the Office Visit benefit, however, any other services will apply toward their applicable benefit level. *Covered charges* for *room and board* will be payable as shown in the applicable Schedule of Medical Benefits. ***Pre-certification* is required for inpatient admissions.**

    a. *Room and board* charges made by a *hospital* having only private rooms will be paid at the semi-private room rate when such semi-private room rate is available.

    b. Charges for an *intensive care unit* stay are payable as described in the applicable Schedule of Medical Benefits and do not apply to the semi-private room rate.

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

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

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

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

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

32. **Infertility.** Please refer to the **INFERTILITY BENEFITS, PROGYNY** section.

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

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

    a. following cataract surgery

    b. damaged lens due to eye trauma

    c. congenital cataract

    d. congenital aphakia

    e. lens subluxation/displacement

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

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

A clear lens extraction intraocular lens implant for the correction of refractive error is not considered *medically necessary*. Intraocular lenses used to correct presbyopia and astigmatism are not considered *medically necessary*.

35. **Massage Therapy.** Massage therapy is covered the same as any other *illness* when performed by a *physician* acting within the scope of his/her license.
36. **Mastectomy bras and camisoles:** Limited to four (4) items per *plan participant* per *calendar year*.
37. **Maternity.** *Pregnancy* and complications of *pregnancy* shall be covered as any other *illness* for the *employee* or *dependent*. Benefits include pre-and post-natal care, obstetrical delivery, caesarean section, miscarriage, and *complications of pregnancy*. Charges for a planned home birth will be considered a covered benefit.

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

    Delivery and hospitalization stay may be subject to *pre-certification* if over the standards set forth in the Newborns' and Mothers' Health Protection Act. Refer to the plan document for the statement of rights under the Newborns' and Mothers' Health Protection Act for certain protections mothers and newborns have regarding *hospital* stays.
38. **Medical Foods.** Enteral and parenteral medical foods are considered a *covered charge* if intravenous therapy (IV) or tube feedings are *medically necessary*. Medical foods taken orally are **not** covered under the *Plan*, except for PKU formula when *medically necessary*.
39. **Medical Supplies.** Charges for surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations. Also included are supplies and dressings when *medically necessary* for surgical wounds, cancer, burns, diabetic ulcers, colostomy bags and catheters, ostomy supplies, supplies for insulin pumps and continuous blood glucose monitor, and surgical and orthopedic braces, unless covered under the **Prescription Drug Benefits** section.

    The following items will also be considered medical supplies:

    a. **Jobst/compression stockings:** Limited to four (4) units, or two (2) pair, per *plan participant* per *calendar year*.
    b. **Mastectomy bras and camisoles:** Limited to four (4) items per *plan participant* per *calendar year*.

    Refer to the *Preventive Care* provision or visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** and **https://www.irs.gov/pub/irs-drop/n-04-23.pdf** for a current listing of medical supplies related *preventive care* benefits.
40. **Mental Disorders and Substance Use disorder.** Coverage for mental health treatments are considered the same as benefits provided for other medical conditions. *Inpatient* and *outpatient* treatment for *mental disorders* will be eligible when rendered by a licensed psychiatrist or licensed psychologist or when rendered by a *physician* as defined. *Covered charges* will be payable as shown in the Schedule of Medical Benefits.

    Benefits include the following services provided on either an *outpatient* or *inpatient* basis:

    a. counseling services
    b. crisis intervention
    c. diagnostic evaluations and assessment
    d. intensive outpatient treatment
    e. *marriage and family therapy*
    f. medication management
    g. partial hospitalization/day treatment
    h. referral services
    i. treatment and/or procedures
    j. treatment planning

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

***Pre-certification* is required for inpatient admissions, partial hospitalization, and intensive outpatient day treatment.**

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

41. **Midwife Services.** Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of his/her license. This *Plan* will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries. Please see the Maternity benefit for home birth coverage or limitations.
42. **Morbid Obesity.** Benefits for *morbid obesity* surgery will be covered when *medically necessary*, only through SurgeryPlus, as shown in the applicable Schedule of Medical Benefits.
43. **National/Public Health Emergency.** In the event of a declared National Health Emergency (or Public Health Emergency), the *Plan* will offer coverage as mandated for the condition~~(s)~~ as required by federal regulation. The *Plan* will also cover medications authorized for emergency use by the appropriate federal agencies in the event of a public health emergency. This provision shall override any potentially conflicting, specific exclusions, defined terms, or other *Plan* provisions as necessary to provide, and limited to, any mandated services as outlined in the national and/or public health emergency, and corresponding regulation(s). Such coverage shall remain in effect until the national and/or public health emergency, as declared by the governing federal agency, has ended.
44. **Nutritional Counseling.** Also known as nutritional therapy. Covered only as part of diabetic education, when performed in conjunction with a mental/substance use disorder, and/or in preparation for bariatric treatment.
45. **Oral Surgery.** Maxillofacial *surgical procedures* limited to:
    a. excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths
    b. incision and drainage of facial abscess
    c. *surgical procedures* involving salivary glands and ducts and non-dental related procedures of the accessory sinuses
    d. removal of all teeth at an inpatient or outpatient hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the *plan participant* can undergo radiation therapy for a covered medical condition
    e. organ transplant preparation
    f. orthognathic surgery/LeFort procedures to correct malposition in the bones of the jaw

    Services rendered by a *non-network* dentist or oral surgeon will be covered at the *network* benefit level.

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

    Replacement of purchased equipment is covered if either:

    a. the replacement is needed because of a change in your physical condition
    b. it is likely to cost less to replace the item than to repair the existing item or rent a similar item

    ***Pre-certification* is required when the purchase price is expected to exceed $1,000.**

36. **Physician Care.** The professional services of a *physician* for medical services. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed the surgeon's *maximum allowable charge*.
47. **Preventive Care.** Benefits will be provided for *preventive care,* including, but not limited to:

a. **Immunizations.** Pediatric and adult preventive vaccinations, inoculations, and immunizations, as recommended by the Centers for Disease Control and Prevention (CDC), including, but not limited to:

   i. **HPV vaccine.** For male and female *plan participants* ages nine (9) through forty-five (45).

   ii. **Influenza vaccine.**

   iii. **Shingles vaccine.** For *plan participants* age fifty (50) and over.

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

b. **Adult physical examination, well-baby, and well-child examinations.**

c. **Colorectal Cancer Screening.**

d. **Gynecological exam.**

e. **Mammogram.**

f. **Lactation Counseling.**

g. **Pap Smear.** Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.

h. **Prostate Specific Antigen Test.**

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

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

k. **Routine hearing exam.** Charges are limited to one (1) routine hearing exam per *calendar year* per *plan participant*.

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

https://www.healthcare.gov/coverage/preventive-care-benefits/ or
http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
https://www.irs.gov/pub/irs-drop/n-04-23.pdf
https://www.irs.gov/pub/irs-drop/n-19-45.pdf

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

    Replacement of purchased equipment is covered if either:

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

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

    ***Pre-certification* is required when the purchase price is expected to exceed $1,000.**

49. **Reconstructive, Cosmetic, or Plastic Surgery** The following *covered charges* described below for Reconstructive, Cosmetic, or Plastic Surgery will be the same as for treatment of any other *illness:*

    a. Treatment provided for the correction of defects *incurred* in an *accidental injury* sustained by the *plan participant*.

    b. Treatment provided for reconstructive *surgery* following cancer *surgery*.

    c. *Surgery* performed on a newborn child for the treatment or correction of a congenital defect.

d. *Surgery* performed on a covered *dependent* child (other than a newborn child) under the age of nineteen (19) for the treatment or correction of a congenital defect other than conditions of the breast.

e. Reconstruction of the breast on which *mastectomy* has been performed; *surgery* and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the *mastectomy*.

f. Reconstructive surgery performed on a covered *dependent* child under the age of nineteen (19) due to craniofacial abnormalities to improve the function of or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or *disease*.

All other reconstructive *surgeries* will be covered under the *Plan* when *medically necessary*.

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

50. **Rehabilitation/Habilitation Services.** Services include physical therapy, occupational therapy, and speech therapy rendered on an *inpatient* or *outpatient* basis. *Inpatient* therapy applies to the Skilled Nursing Facility/Rehabilitation Facility *calendar year* maximum. ***Pre-certification* is required for outpatient rehabilitation services (physical, occupational, and speech therapy) in excess of eighteen (18) visits per therapy type per calendar year.** Refer to the applicable Schedule of Medical Benefits for any limitations that may apply. Wound debridement services do not apply toward the Rehabilitation Therapy maximum and do not require *pre-certification*.

    a. **Speech therapy**. Benefits are available for the services of a *physician* or *other provider* to restore loss of or correct an impaired speech or hearing function. Benefits include aural therapy following a covered implantable hearing device.

    b. **Therapies for children with developmental delays. B**enefits are available to a covered *dependent* child for the necessary rehabilitative and habilitative therapies in accordance with an individualized family service plan.

        Such therapies include:

        i. occupational therapy evaluations and services

        ii. physical therapy evaluations and services

        iii. speech therapy evaluations and services

        iv. dietary or nutritional evaluations

        The individualized family service plan must be submitted to the *Claim Administrator* prior to the commencement of services and when the individualized family service plan is altered.

        Once the child reaches the age of three (3), when services under the individualized family service plan are completed, *covered charges*, as otherwise covered under this *Plan*, will be available. All contractual provisions of this *Plan* will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

        Developmental delay means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

        i. cognitive development

        ii. physical development

        iii. communication development

        iv. social or emotional development

        v. adaptive development

        Individualized family service plan means an initial and ongoing treatment plan.

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

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

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

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

b. The benefit is limited to *allowable charges* for well-baby care after birth while the newborn child is *hospital* confined as a result of the child's birth.

52. **School**. Services performed in a school setting. This does not include services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school are also not covered.

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

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

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

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

    ***Pre-certification* is required for inpatient admissions.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

54. **Sleep Disorders/Sleep Studies.** Care and treatment for sleep disorders, including sleep studies performed in the home, when *medically necessary*. ***Pre-certification* is required for sleep studies.**

55. **Sterilization.** Services for vasectomy or other voluntary sterilization procedures for male *plan participants*. Female sterilization and family planning counseling is covered under the Preventive Care provision of this *Plan*. The *Plan* does not cover the reversal of voluntary sterilization procedures, including related follow-up care.

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

    If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed the surgeon's *maximum allowable charge*.

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

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

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

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

57. **Transplants.** Subject to the conditions described below, benefits for covered services and supplies provided to a *plan participant* by a *hospital*, *physician*, or *other provider* related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:

    a. The transplant procedure is not *experimental/investigational* in nature.

    b. Donated human organs or tissue or an FDA-approved artificial device are used.

c. The recipient is a *participant* under the *Plan*.

d. The transplant procedure is *pre-certified* as required under the *Plan*.

e. The *plan participant* meets all of the criteria established by the *Claim Administrator* in pertinent written medical policies.

f. The *plan participant* meets all of the protocols established by the *hospital* in which the transplant is performed.

Covered services and supplies 'related to' an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

Benefits are available and will be determined on the same basis as any other *illness* when the transplant procedure is considered *medically necessary* and meets all of the conditions cited above. Benefits will be available for:

a. a recipient who is covered under this *Plan*

b. a donor who is a *participant* under this *Plan*

Covered charges include services and supplies provided for any of the following:

a. evaluation of organs or tissues including, but not limited to, the determination of tissue matches

b. donor search and acceptability testing of potential live donors

c. removal of organs or tissues from living or deceased donors

d. transportation and short-term storage of donated organs or tissues

No benefits are available for a *plan participant* for the following services or supplies:

a. expenses related to maintenance of life of a donor for purposes of organ or tissue donation

b. purchase of the organ or tissue

c. organs or tissue (xenograft) obtained from another species

***Pre-certification* is required for any organ or tissue transplant.** Review the **Health Care Management Program** section in this benefit booklet for more specific information about *pre-certification*.

a. Such specific *pre-certification* is required even if the patient is already a patient in a *hospital* under another *pre-certification* authorization.

b. At the time of *pre-certification*, the *Claim Administrator* will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the *Claim Administrator* determines that an extension is *medically necessary*.

No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which the *Claim Administrator* considers to be *experimental/investigational*.

58. **Travel and Lodging.** Coverage is available for reimbursement of travel and lodging expenses *incurred* during the transplant (immediately prior to and after the transplant) and CAR T therapy for the *plan participant* and companion(s)up to the benefit maximum listed in the applicable Schedule of Medical Benefits.

    These benefits will be reimbursed upon the submission to the *Plan* of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service provider. The listed expenses must be *incurred* within five (5) days prior to the transplant and one hundred twenty (120) days after the transplant. The *Plan Administrator* reserves the right not to reimburse any such expenses that it, in its sole discretion, deems inappropriate, excessive, or not in keeping with the intent of this provision.

59. **Urgent Care.** Benefits for *covered charges* for urgent care will be determined as shown in the applicable Schedule of Medical Benefits. Urgent care means the delivery of medical care in a facility dedicated to the delivery of scheduled or unscheduled, walk-in care outside of a *hospital* emergency room/treatment room department or *physician's* office. The necessary medical care is for a condition that is not life-threatening.

60. **Virtual Visits.**
61. **Wigs.** Charges associated with the purchase of a wig after chemotherapy or radiation therapy, limited to $500 per *calendar year*.
62. **X-Rays.** Diagnostic x-rays.

B. Medical Plan Exclusions

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

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

1. **Abortion.** Services, supplies, care, or treatment in connection with an abortion unless the life of the mother is endangered by the continued *pregnancy* or the *pregnancy* is the result of rape or incest.
2. **Adoptive Cell Therapy.** Except as specifically covered herein.
3. **Allergy.** Any services or supplies provided primarily for any of the following:
    a. environmental sensitivity
    b. clinical ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists
    c. *inpatient* allergy testing or treatment
4. **Alternative Medicine.** Holistic or homeopathic treatment, naturopathic services, and thermography, including drugs. Any services or supplies provided for the following treatment modalities:
    a. acupuncture
    b. intersegmental traction
    c. surface EMGs
    d. spinal manipulation under anesthesia
    e. muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph, and Dynatron
5. **Applied Behavioral Analysis Therapy (ABA).** ABA therapy done in the home is excluded.
6. **Aquatic Therapy.**
7. **Armed Forces.** Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any *plan participant* in the armed forces of a government.
8. **Athletic Training.**
9. **Behavioral.** Diagnosis and treatment of behavioral problems and learning disabilities; behavior modification, sensitivity training, hypnosis, or electro-hypnosis; special education, therapy, or care for learning deficiencies or behavioral problems, whether or not associated with a manifest *mental disorder* or other disturbances.
10. **Biofeedback.** Biofeedback (except for an *acquired brain injury* diagnosis) or other behavior modification services.
11. **Bone Marrow.** Benefits in connection with harvesting and reinfusion of bone marrow for the treatment of an *illness*, except as otherwise specifically provided herein.
12. **Chelation Therapy.** Except for treatment of acute metal poisoning.
13. **Clinical Trials.** The following items are excluded from *approved clinical trial* coverage under this *Plan*:
    a. the *investigational* item, device, or service, itself
    b. items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the patient
    c. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

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

    The *Plan* does not cover routine patient care services that are provided outside of this *Plan's* health care provider *in-network* unless *out-of-network* benefits are otherwise provided under this *Plan*.

14. **Complications from a Non-Covered Service.** Care, services, or treatment required as a result of complications from a treatment not covered under the *Plan*.
15. **Cord Blood.** Harvesting and storage of umbilical cord blood.
16. **Cosmetic.** Cosmetic or reconstructive procedures and attendant hospitalization, except as stated in the Reconstructive, Cosmetic, or Plastic Surgery provision in the Covered Medical Charges subsection. Cosmetic procedures will not be covered regardless of the fact that the lack of correction causes emotional or psychological effects. Complications or subsequent *surgery* related in any way to any previous cosmetic procedure shall not be covered, regardless of *medical necessity*.
17. **Counseling.** Benefits for counseling in the absence of *illness* or *injury*, including, but not limited to, education, social, behavioral, or recreational therapy; sex counseling; or counseling provided by a *plan participant's* friends, *employer*, school counselor, or school teacher.
18. **Court-Ordered Treatment.** Any treatment of a *plan participant* in a public or private institution as the result of a court order due to a criminal offense. This exclusion does not apply to *mental health or substance use disorder holds*.
19. **COVID-19 Services.** Dental personal protection equipment (PPE). At-home (over-the-counter) COVID-19 tests are excluded under the medical plan.
20. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, or *custodial care*.
21. **Dental Care.** Normal dental care benefits, including any dental, gum treatments, or oral *surgery* except as otherwise specifically provided herein.
22. **Dietary and Nutritional Services**. Any services or supplies provided for *dietary and nutritional services*, except as listed herein.
23. **Educational or Vocational Testing**. Services for educational or vocational testing or training. Educational services such as asthma self-management education and Lamaze, except as otherwise listed herein.
24. **Error.** Any charge for care, supplies, treatment, and/or services that are required to treat *injuries* that are sustained, or an *illness* that is contracted, including infections and complications, while the *plan participant* was under, and due to, the care of a provider wherein such *illness*, *injury*, infection, or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the *Plan Administrator*, in its sole discretion, unreasonably gave rise to the expense.
25. **Examinations.** Any health examination required by any law of a government to secure insurance or school admissions (including sports physicals) or professional or other licenses, except as required under applicable federal law. Administrative/return-to-work testing related to COVID-19, except as required under applicable federal law.
26. **Excess Charges.** Any charge for care, supplies, treatment, and/or services that are not payable under the *Plan* due to application of any *Plan* maximum charges which are in excess of the *maximum allowable charge*, or services not deemed to be *reasonable* or *medically necessary*, based upon the *Plan Administrator's* determination as set forth by and within the terms of this document.
27. **Exercise Programs.** Exercise programs for treatment of any condition, except for *physician* supervised cardiac rehabilitation or as listed herein.
28. **Experimental/Investigational.** Care and treatment that is *experimental/investigational*. This exclusion shall not apply if the charge is for routine patient care for costs *incurred* by a *qualified individual* who is a participant in an *approved clinical trial*. Charges will be covered only to the extent specifically set forth in this benefit booklet.
29. **Family History.** Charges related to services provided with a diagnosis of family history, except as may be covered under the Preventive Care provision or under applicable federal law.
30. **Foot Care.** Services for routine, palliative or cosmetic foot care. Examples include flat foot conditions, supportive devices for the foot (orthotics), treatment of subluxation of the foot, care of corns, bunions (except capsular or bone *surgery*), callouses, toe nails, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, except for the treatment of severe systemic *disease* or unless *medically necessary*.

31. **Foreign Travel.** Expenses for planned and/or routine services received or supplies purchased outside the United States, including services rendered on a cruise ship, are excluded under the *Plan*. Services in the case of a *medical emergency* are a *covered charge*.
32. **Gender.** Care, services, or treatment for transsexualism, gender dysphoria, or sexual reassignment or change, including drugs, medication, implants, hormone therapy, other surgical treatment, or psychiatric care or treatment.
33. **Government Coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid, a Veteran's Administration facility, or when otherwise prohibited by applicable law. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military service-related *illness* or *injury*, benefits are covered by the *Plan* to the extent those services are *medically necessary* and the charges are within this *Plan's maximum allowable charge*.
34. **Growth Hormones.** Refer to the **Prescription Drug Benefits** section for details on coverage.
35. **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a *physician*, except for wigs as shown in the applicable Schedule of Medical Benefits. This exclusion does not apply to hair loss services attributed to a covered medical condition.
36. **Hearing Aids and Implantable Hearing Devices.** Charges for services or supplies in connection with hearing aids (including over-the-counter), implantable hearing devices, (other than cochlear implants) and exams for their fitting.
37. **Hospice Care.** Services for spiritual counseling; services performed by a family member or volunteer workers, homemaker, or housekeeping services; food services (such as Meals on Wheels); legal and financial counseling services; and services or supplies not included in the *hospice care plan* or not specifically set forth as a hospice benefit.
38. **Hospital Employees.** Professional services billed by a *physician* or nurse who is an *employee* of a *hospital* or *skilled nursing facility* and paid by the *hospital* or facility for the service.
39. **Hospital Services.** *Hospital* services, as identified through the Plan's internal review or *claims* audit procedure, when such services could have been done adequately and safely on an *outpatient* basis.
40. **Immediate Family Member.** Any charge for care, supplies, treatment, and/or services that are rendered by a provider who is related to the *plan participant* by blood or marriage or who ordinarily dwells in the *plan participant's* household.
41. **Immunizations.** Immunizations and vaccinations for the purpose of travel outside of the United States.
42. **Impotence.** Care, treatment, services, supplies, or medication in connection with treatment for impotence.
43. **Infertility.** Please refer to the **INFERTILITY BENEFITS, PROGYNY** section.
44. **Level of Care/Site of Care.** Services and procedures, as identified through the Plan's *claims* audit procedure, which could have been adequately and safely performed at an appropriate alternative lower level or site of care.
45. **Long Term Care.**
46. **Male Contraceptives.** Any non-prescription contraceptive medications or devices for male use.
47. **Mammoplasty Reduction.** Any services or supplies provided for reduction mammoplasty.
48. **Maternity.** Charges for services related to surrogate *pregnancy*.
49. **Medicare.** Any charge for benefits that are provided, or which would have been provided had the *plan participant* enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (*Medicare*), including any amendments thereto, or under any federal law or regulation, except as provided in the plan document.
50. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
51. **No Legal Obligation.** Any charge for care, supplies, treatment, and/or services that are provided to a *plan participant* for which the provider of a service customarily makes no direct charge, for which the *plan participant* is not legally obligated to pay, or for which no charges would be made in the absence

of this coverage, including, but not limited to, fees, care, supplies, or services for which a person, company, or any other entity except the *plan participant* or this benefit *Plan*, may be liable for necessitating the fees, care, supplies, or services.

52. **No Physician Recommendation.** Care, treatment, services, or supplies not recommended and approved by a *physician*. Treatment, services, or supplies when the *plan participant* is not under the regular care of a *physician*. Regular care means ongoing medical supervision or treatment which is appropriate care for the *injury* or *illness*.
53. **No Signs or Symptoms.** Charges for treatment or services in the absence of signs or symptoms of a specific *injury*, *illness*, or *pregnancy* related condition which is known or reasonably suspected, unless such care is specifically covered herein or required by applicable federal law.
54. **Non-Covered Services.** Any related services to a non-covered service. Related services are:
    a. services in preparation for the non-covered service
    b. services in connection with providing the non-covered service
    c. hospitalization required to perform the non-covered service
    d. services that are usually provided following the non-covered service, such as follow-up care or therapy after *surgery*
55. **Non-Medical Expenses.** Expenses including, but not limited to, those for preparing medical reports or itemized bills, completion of claim forms or medical records unless otherwise required by law, calling a patient to provide their test results, sales tax, shipping and handling, services for telephone consultations, or expenses for failure to keep a scheduled visit or appointment, *physician* or *hospital* stand-by services, holiday or overtime rates, membership or access fees, educational brochures, or reports prepared in connection with litigation.
56. **Non-Prescription Medication.** Drugs and supplies not requiring a prescription order (unless required under applicable federal law), including, but not limited to, aspirin, antacid, benzyl peroxide preparations, cosmetics, medicated soaps, food supplements, syringes, bandages, Antabuse, Minoxidil, or Rogaine hair preparations, special foods or diets, vitamins, minerals, dietary and nutritional supplements, nutritional therapy, *experimental* drugs, including those labeled "Caution: Federal law prohibits dispensing without prescription," and prescription medications related to health care services which are not covered under this *Plan*.
57. **Non-Traditional Therapy Modalities.** Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the Rehabilitation /Habilitation Services provision in the Covered Medical Charges.
58. **Not Actually Rendered.** Any charge for care, supplies, treatment, and/or services that are not actually rendered.
59. **Not Medically Necessary.** Any charge for care, supplies, treatment, and/or services that are not *medically necessary*, unless specifically stated as covered herein.
60. **Obesity.** Any services or supplies provided for reduction of obesity or weight, including *surgical procedures*, even if the *participant* has other health conditions which might be helped by a reduction of obesity or weight, except as federal mandated for healthy diet counseling and obesity screening/counseling as may be provided under the Preventive Care provision or required under applicable federal law. This exclusion does not apply to morbid obesity, as described in the Covered Medical Charges subsection.
61. **Occupational or Workers' Compensation.** Charges for care, supplies, treatment, and/or services for any condition, *illness*, *injury*, or complication thereof arising out of or in the course of employment (including self-employment), or an activity for wage or profit. If you are covered as a *dependent* under this *Plan* and you are self-employed or employed by an *employer* that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers' compensation insurance will cover your costs, but if you do not have such coverage, fail to file, or receive a denial for failure to file timely, fail to file, or receive a denial for failure to file timely, you may end up with no coverage at all.
62. **Oral Solutions.** Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.

63. **Orthognathic Surgery/LeFort Procedures.** Surgery to correct malposition in the bones of the jaw, except as necessary for the treatment or correction of a congenital defect for children under the age of nineteen (19).
64. **Orthotics.** Charges in connection with non-custom molded orthotics.
65. **Over the Counter Items.** Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a *physician* in a non-hospital setting or purchased over the counter for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, and garter belts.

    Note: This exclusion does not apply to podiatric appliances when provided as diabetic equipment, or to breastfeeding equipment and supplies.
66. **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-medical grade stockings/items (except as specified herein), non-prescription drugs and medicines, first-aid supplies, seat risers, and non-hospital adjustable beds.
67. **Personal Injury Insurance.** Expenses in connection with an automobile *accident* for which benefits payable hereunder are, or would be otherwise covered by, mandatory *no-fault automobile insurance* or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the *plan participant* actually had such mandatory coverage. This exclusion does not apply if the *injured* person is a passenger in a non-family owned vehicle or a pedestrian.
68. **Prescription Drugs.** Prescription drugs charges covered under the Prescription Drug Benefits, other than those covered in a *physician's* office or *inpatient* admission.
69. **Prior to Coverage.** Any charge for care, supplies, treatment, and/or services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.
70. **Private Duty Nursing.** Charges in connection with care, treatment, or services of a private duty nurse.
71. **Prohibited by Law.** Any charge for care, supplies, treatment, and/or services to the extent that payment under this *Plan* is prohibited by law.
72. **Repair of Purchased Equipment.** Maintenance and repairs needed due to misuse or abuse are not covered.
73. **Replacement Devices.** Replacement of orthotics or prosthetics such as braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the *plan participant's* physical condition to make the original device no longer functional.
74. **Residential Accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a *hospital*, *hospice unit*, *skilled nursing facility*, *inpatient rehabilitation hospital*, or *residential treatment facility* licensed and regulated by a state or federal agency and is acting within the scope of their license.
75. **Roctavian.**
76. **Sexual Dysfunction.** Any services or supplies provided for, in preparation for, or in conjunction with sexual dysfunctions.
77. **Smoking Cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under the Preventive Care provision. Tobacco cessation care and treatment is otherwise excluded under the Medical Benefits. Refer to the **Prescription Drug Benefits** section for details on coverage of certain tobacco cessation medications.
78. **Specialty Drugs or Specialty Medications**. Drugs or medications on the list for the Mandatory Specialty Pharmacy Program available at **www.MyAmeriBen.com** (or by calling 1-888-265-7790).
79. **Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.
80. **Subrogation, Reimbursement, and/or Third Party Responsibility.** Any charges for care, supplies, treatment, and/or services of an *injury* or *illness* not payable by virtue of the *Plan's* subrogation, reimbursement, and/or third party responsibility provisions. Refer to the **Reimbursement, Subrogation, and Recovery Provisions** section.
81. **Temporomandibular Joint Syndrome (TMJ).** Benefits for medical or dental services and devices for treatment of temporomandibular joint disorders.

82. **Transplants.** Services and supplies that are *incurred* for care and treatment due to a bone marrow, organ, or tissue transplant are subject to the limitations and exclusions stated in the Transplant provision listed in the Covered Medical Charges subsection.

83. **Travel or Accommodations.** Charges for travel accommodations, whether or not recommended by a *physician*, except for ambulance charges defined as a *covered charge* or travel required for an approved organ or tissue transplant. Refer to the Travel provision listed in the Covered Medical Charges subsection. The following expenses are not covered by the *Plan*:

    a. services for a condition that is not directly related, or a direct result, of the transplant

    b. any of the following or similar items associated with travel:

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

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

        iii. mortgage, rent, security deposit, furniture, utility bills, appliances, utensils, vacation/apartment rentals

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

        v. cash advances/lost wages

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

        vii. prepayments or deposits

        viii. taxes

        ix. travel costs for donor companion/caregiver

    c. return visits for the donor for a treatment of an *illness* found during the evaluation

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

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

    b. diagnosis and treatment of refractive errors, including routine eye examinations, purchase, fitting, and repair of eyeglasses or lenses and associated supplies, except one (1) pair of eyeglasses or contact lenses is payable as following ocular surgery when the lens of the eye has been removed such as with a cataract extraction

        This exclusion applies even when services are performed in conjunction with a medical diagnosis.

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

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

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

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

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

SECTION VI—OUTPATIENT DIALYSIS SERVICES

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

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

A. Coordination with Medicare

If you are diagnosed with a condition requiring dialysis, you may be able to enroll in *Medicare*. Upon beginning dialysis treatments, *Medicare*, if applicable, will coordinate benefits with the *Plan* as the secondary payer for months four (4) through thirty-three (33) of the coordination period while you are receiving dialysis treatments. Your *outpatient* dialysis medical *claims* as described in this section will be considered at 140% of *Medicare's* reimbursement level.

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

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

Refer to the plan document for more information regarding coordination of benefits.

B. Medical Management

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

C. ID Cards

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

D. Submitting Outpatient Dialysis Claims

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

AmeriBen
P.O. Box 7186
Boise, ID 83707

Please refer to the plan document for information regarding filing *claims*.

SECTION VII—SURGERYPLUS BENEFIT

SurgeryPlus is a supplemental benefit that helps you (and any covered *dependents* age 17+) to plan and pay for certain non-emergency covered medical procedures. When your doctor recommends *surgery*, you call SurgeryPlus. SurgeryPlus helps you find a board-certified surgeon with an extensive history of quality. They set up your initial consultation and walk you through each step of the planning process. If there aren't any SurgeryPlus surgeons near you, SurgeryPlus plans and pays for your travel too. SurgeryPlus negotiates all costs before you have *surgery*, then coordinates the payment for you. The SurgeryPlus Benefit is offered by the *Plan*, in partnership with EmployerDirect Healthcare.

A. How It Works

When you use SurgeryPlus, you will receive assistance both planning and paying for covered medical procedures. Your SurgeryPlus Care Coordinator will help you through the entire process. To receive SurgeryPlus benefits:

1. You must call a SurgeryPlus Care Coordinator **before** you begin planning your surgery/procedure.

   Member Care Coordinators are available at 1-855-200-9512.

2. You must agree to supply your medical records and any other pertinent information to the selected SurgeryPlus doctor so he/she may assess:
   a. the medical necessity of the requested service
   b. your suitability for the prospective treatment or procedure, including any necessary travel
   This assessment is referred to as the initial review/consultation.
3. Based on the initial review/consultation, the SurgeryPlus *physician* will decide whether to accept your case.
4. You must accept and agree to the standard terms of treatment of the SurgeryPlus doctor. Receiving an initial review/consultation does not commit you to proceed with treatment from the SurgeryPlus doctor.

If you are not satisfied with your SurgeryPlus *physician* or his/her initial review/consultation, you may contact your Care Coordinator and arrange for a second opinion with another SurgeryPlus doctor.

B. SurgeryPlus Care Coordinators

SurgeryPlus Care Coordinators are your connection to the SurgeryPlus benefit. They help you find a great doctor for your procedure, schedule your procedure appointments, make travel reservations (if travel is required), transfer your medical records, and coordinate all your *surgery* bills.

Throughout the planning process, you will work with the same Care Coordinator. Your SurgeryPlus Care Coordinator will provide you one-on-one, personalized help each step of the way.

C. SurgeryPlus Travel Benefit

Your SurgeryPlus benefit will also pay for necessary travel associated with the covered procedure. The specific travel benefit depends on the procedure, the provider, and the distance between the *provider* and a *plan participant's* residence. For procedures requiring *inpatient* admission or overnight recovery, the travel benefit covers the patient and one companion for a limited amount of time. Only travel arrangements made through your Care Coordinator are eligible for coverage under the SurgeryPlus benefit.

D. Payment

When you use SurgeryPlus, the surgery cost for the episode of care (as defined below) is paid as follows:

1. You (*plan participant*) must meet the *deductible* amount (if applicable) under your general health plan prior to the SurgeryPlus benefit becoming available. Once a *plan participant* has incurred the maximum *deductible*, the remaining amount will be paid by the *Plan* through the SurgeryPlus benefit. You do not pay any *copays* or *coinsurance* amounts.

2. If you have already met your annual *deductible* before your *surgery*, the *Plan* pays the full cost of the episode of care.

Example: Fred uses SurgeryPlus to get a rotator cuff repair. His annual *deductible* is $1,500. He has met $1,000 of his *deductible* by the time he has *surgery*. The rotator cuff repair procedure costs $6,400. Fred pays $500 to meet his deductible. The *Plan* pays the remaining $5,900 for the episode of care.

**Please note that the SurgeryPlus benefit covers only those services contained in the episode of care and terminates upon the *plan participant's* discharge from the facility by *provider*. Coverage for payment of any medical services rendered subsequent to the termination of an episode of care shall be the responsibility of the *plan participant* and the *Plan*. Please see examples Limitations and Disclosures below for more information.

E. Covered Surgeries and Procedures

You can utilize the SurgeryPlus benefit for the following procedures (this list is subject to change):

Major Procedures

1. orthopedic
    a. knee replacement (partial, unilateral and bilateral)
    b. knee replacement revision
    c. hip replacement (partial, unilateral and bilateral)
    d. hip replacement revision
    e. shoulder replacement (partial, unilateral and bilateral)
    f. shoulder replacement revision
    g. ankle replacement
    h. wrist replacement
    i. elbow replacement
2. spine (non-emergent)
    a. laminotomy (Cervical, Lumbar, Thoraic)
    b. laminectomy (Cervical, Lumbar, Thoraic)
    c. disc (Cervical, Lumbar, Thoracic)
    d. anterior lumbar interbody fusion (ALIF)
    e. posterior lumbar interbody fusion (PLIF)
    f. 360 fusion
    g. post fusion and decompression
    h. anterior cervical fusion (ACF)
    i. posterior cervical fusion (PCF)
    j. artificial disc
    k. pain management procedures (spine only)
3. general surgery
    a. hysterectomy
    b. bladder repair (anterior or posterior)
    c. thyroidectomy
4. bariatrics (only covered through SurgeryPlus)
    a. gastric bypass
    b. laparoscopic gastric bypass
    c. laparoscopic sleeve gastrectomy
5. cardiac
    a. cardiac valve surgery
    b. cardiac defibrillator implant
    c. permanent pacemaker implant
    d. cardiac pacemaker device replacement

Minor Procedures

1. outpatient procedures
    a. knee arthroscopy/meniscus
    b. shoulder arthroscopy
    c. hip arthroscopy
    d. ankle arthroscopy
    e. MCL repair
    f. ACL repair
    g. PCL repair
    h. bunionectomy
    i. hammer toe repair
    j. bicep tendon repair
    k. rotator cuff repair
    l. carpal tunnel release
    m. hernia repair (all types)
    n. gallbladder removal
    o. ankle fusion
    p. wrist fusion
    q. elbow

Your SurgeryPlus Care Coordinator must confirm if your *surgical procedure* is eligible for the SurgeryPlus benefit.

F. Limitations and Disclosures

SurgeryPlus is a service offered by EmployerDirect that provides non-clinical care coordination for planned medical procedures. EmployerDirect does not itself provide any medical care, medical advice, or recommendation as to selection of any course of treatment or provider, including EmployerDirect's participating providers.

Certain examinations, tests, treatments, or other medical services may be required prior to or following a planned medical procedure with a SurgeryPlus provider. Any medical services performed by anyone other than a SurgeryPlus doctor, including pre- and post-care, shall be subject to the coverage limits and other terms of the *Plan*.

All *claims* paid by the *Plan* for your SurgeryPlus benefit are included toward and subject to your *calendar year* Maximum Benefit under the *Plan*.

Subsequent to an episode of care, if a *plan participant* needs *emergency care* for any reason this would be subject to coverage under the *Plan*. The episode of care ends when the *plan participant* is discharged from the facility.

G. SurgeryPlus Exclusions

1. Diagnostic Studies and Imaging
2. Physical Therapy
3. Durable Medical Equipment
4. Prescriptions
5. Lab Work
6. Pain Injections that are not Spine Related
7. Pre-Operative Labs and Testing
   Note: Pre-operative labs and testing will be done at your primary care physician's office and will be submitted to your current medical health insurance.
8. Complications after the 'Episode of Care'

For purposes of this benefit booklet, 'episode of care' means: (i) all services rendered by an EDH provider and provider's professional and medical staff, as applicable and (ii) all *hospital* or facility-related expenses under the diagnosis case code. The episode of care begins on the day the *plan participant* first receives services from the provider related to the diagnosis case code and ends when the *plan participant* is discharged from the *hospital* or facility to return or travel home. Services and expenses under the diagnosis case code commonly included in the episode of care are equipment used while in *hospital* or facility, in-hospital or in-facility medications or biologics and supplies, implants, labs, in-*hospital* meals, *hospital* confinement days, pre and post in-hospital or in-facility nursing care and in-hospital physical therapy and follow-up consultations, and any other *medically necessary* care related to the diagnosis case code rendered prior to discharge. An episode of care shall not include (i) diagnostic testing in advance to determine whether a procedure is necessary; (ii) convenience expenses; (iii) procedures or care that are not *medically necessary,* and (iv) and serious reportable events (SREs) as defined by the National Quality Forum at **http://www.qualityforum.org/Home.aspx**.

SECTION VIII—INFERTILITY BENEFITS, PROGYNY

Infertility services are not included under the *network* arrangement of this *Plan* and are instead a carve-out with Progyny. To begin an *infertility* treatment plan, please contact Progyny at 1-833-278-1139 or at **https://progyny.com/find-a-provider** to be connected to a Progyny PCA.

There are no benefits available for infertility services from a non-Progyny provider, even if the provider is in the network arrangement for the Medical Benefits under the Plan. You pay the entire cost of any infertility services you receive from a non-Progyny provider.

A. What the Progyny SMART Cycle Covers

1. Two (2) Smart Cycles per lifetime subject to the plan benefits – a 3rd Smart Cycle per lifetime may be granted should the initial two (2) Smart Cycles be unsuccessful
2. Pre-treatment counseling, advice, and logistical support
3. Information about egg freezing, if applicable
4. Consultative services for people interested in surrogacy, adoption, and egg/sperm donor services
5. Family building strategies for same sex relationships
6. Diagnostic testing, transvaginal ultrasounds, and IVF
7. IUI and ICSI (Intracytoplasmic Sperm Injection)
8. PGS (Pre-implantation genetic screening) and PGD (pre-implantation genetic diagnosis)
9. Embryo assessment and transfer
10. Elective fertility preservation (egg, embryo, ovarian tissue, or sperm) with up to one (1) year of storage will be considered for participants who are undergoing required treatments for cancer or other medical treatments which can result in infertility
11. Surrogacy reimbursement – up to $10,000 per child reimbursement for surrogacy expenses to be administered by Progyny (your Progyny PCA will provide you with the claim form)

B. Progyny SMART Cycle Exclusions

The following exclusions apply for both the patient and the surrogacy/donor:

1. the purchase of donor sperm, oocytes, or embryos
2. any charges associated with care of the donor required for donor oocytes retrievals or transfer or gestational carriers (surrogacy)
3. all charges associated with a gestational carrier program for the person acting as the carrier, including but not limited to, fees for laboratory test
4. the purchase and use of home ovulation prediction kits
5. coverage for a dependent child (under age of 26) unless pursuing oncofertility treatment
6. non-genetic disorder reproductive treatments done for purposes of gender selection
7. fertility services following a voluntary sterilization procedure
8. expenses already paid for or reimbursed by another employer, benefit, program, or party
9. costs paid using funds received form any federal, state, or local program
10. Expenses allowed as a credit or deduction under any other federal income tax rule
11. surrogacy or donation arrangements that are not legally recognized
12. any expenses that violate state or federal law
13. medical expenses related to an intended parent's pregnancy (must be billed to medical)

C. Coordination with Progyny

All fees below may **not** be covered by another source, in order to qualify for reimbursement:

1. surrogacy or donor agency fees
2. legal fees, including:
    a. attorney fees for both intended parents and surrogates
    b. court fees
    c. fees associated with the adoption of a child through a legally recognized surrogate arrangement
3. Screening costs:
    a. gestational carrier
    b. egg donor
    c. sperm donor
4. egg or sperm shipping and transport fees
5. egg or sperm retrieval fees
6. IVF and medical costs related to surrogacy or egg/sperm donation
7. medical expenses related to a surrogate's pregnancy (which may include but are not limited to: surrogate's maternity insurance, surrogate's deductible, and surrogate's co-insurance)
8. travel expenses for the intended parents or surrogate related to the surrogacy or donor services
9. surrogate escrow funds
10. Compensation for:
    a. gestational carrier
    b. egg donor
    c. sperm donor

D. Medical Management

All *infertility* services require *pre-certification*. To begin the *pre-certification* process, call Progyny at 1-833-278-1139.

SECTION IX—HEALTH CARE MANAGEMENT PROGRAM

A. Introduction

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

The scope of the Health Care Management Program consists of the following components (each of which will be further discussed in this section):

- Utilization Review
- Concurrent Review and Discharge Planning
- Case Management
- Maternal Health Program
- Tria Health Pharmacy Advocate Program

B. Utilization Review

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

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

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

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

Elements of the Utilization Review Program

The program consists of:

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

What Services Must Be Pre-Certified (Approved Before they are Provided)

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

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

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

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)
    a. surgical and non-surgical (excluding routine vaginal or cesarean deliveries)

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

c. *skilled nursing facility*/rehabilitation facility

d. *inpatient* mental health/*substance use disorder* treatment

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

2. chemotherapy drugs/infusions and radiation treatments (except proton beam therapy)
3. clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition

   This *Plan* does not cover clinical trials related to other *diseases* or conditions. Refer to the **Medical Benefits** section of this benefit booklet for a further description and limitations of this benefit.
4. dialysis
5. *durable medical equipment* in excess of $1,000 (purchase price only)
6. genetic/genomic testing, other than non-invasive pre-natal testing (NIPT)
7. *gene therapy*
8. *adoptive cell therapy* (limited to CAR T therapy)
9. *home health care services and supplies*
10. *home infusion*
11. *inpatient* and *outpatient surgery*

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

    a. office *surgeries*

    b. all colonoscopies and sigmoidoscopies (screening and diagnostic)

    c. elective female sterilization procedures

    d. intra-articular hyaluronic acid injections
12. non-emergent air ambulance
13. orthotics/prosthetics in excess of $1,000 purchase price
14. *outpatient* imaging – Computed Tomographic (CT) studies, MRI/MRA, nuclear medicine (including SPECT scans), and PET scans (excluding services rendered in an emergency room setting)
15. *outpatient* physical therapy, occupational therapy, and speech therapy in excess of eighteen (18) visits per therapy type per *calendar year*
16. sleep studies
17. transplant, including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy

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

C. How to Request Pre-Certification

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

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

1. the name of the *plan participant* and relationship to the covered *employee*
2. the name, *employee* identification number, and address of the covered *employee*

3. the name of the *employer*
4. the name and telephone number of the attending *physician*
5. the name of the *medical care facility*, proposed date of admission, and proposed length of stay
6. the proposed medical services

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

The *Medical Management Administrator* will determine the number of days of *medical care facility* confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

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

Note: If your admission or service is determined to **not** be *medically necessary*, you may pursue an *appeal* by following the provisions described in the plan document. The *plan participant* and provider will be informed of any denial or non-certification in writing.

D. Penalty for Failure to Pre-Certify

When the required *pre-certification* procedures are followed, your benefits will be unaffected. However, if you do not follow the *pre-certification* requirements outlined above, **you may be subject to a $250 penalty for any resulting *claims***. Penalty will be applied to the facility charge, if applicable. Amounts assessed under this penalty will not go towards satisfaction of your *out-of-pocket limit*.

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

Pre-certification decisions are considered *claims* decisions that are subject to *appeal*. Refer to the plan document for details on how to *appeal* and the timeframes for *appealing* a *pre-service claim* decision.

F. Concurrent Review and Discharge Planning

How Concurrent Review Works

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

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

How to File a Concurrent Claim for Benefits under this Plan

Refer to the plan document for details on how to *appeal* a denial of a concurrent review. No benefits will be paid for any charges related to days of confinement to a *hospital* or other *health care facility* that have not been determined to be *medically necessary* by the *Medical Management Administrator*.

G. Case Management

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

medical practice. Case Management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients, and others.

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

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

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

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

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

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

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

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

H. Maternal Health Program

Your *employer* has contracted with Baby Steps, AmeriBen's Maternal Health Program, as part of your healthcare coverage through the *Plan*. This program provides education, support, and a personal nurse who will help you and your baby stay healthy and avoid complications—before, during, and after your *pregnancy*.

How the Maternal Health Program Works

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

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

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

H. Tria Health Pharmacy Advocate Program

The Tria Health program is designed to help *plan participants* understand their prescription drug benefits and to help you avoid unnecessary expenses, such as a co-pay for a doctor's visit when you just need to talk about

a medication question with a pharmacist. Your *employer* has contracted with Tria Health Pharmacy Advocate Program as part of your healthcare coverage through the *Plan*. The Tria Health program, which is separate from the Prescription Drug Benefits program, is a telehealth benefit that gives you the opportunity to talk with a pharmacist over the phone, who acts as your personal medication expert, to make sure all of your medications are safe, affordable, and effective. The Tria Health program pharmacist will work with you, your doctor, and your pharmacy to efficiently coordinate your care.

Who should participate in the Tria Health Pharmacy Advocate Program?

This program is recommended for individuals who have the following conditions and take multiple medications:

- Asthma/COPD
- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Mental Health
- Migraines
- Osteoporosis
- Or any other "specialty" conditions (please refer to **www.triahealth.com/enroll** for a complete list)

How the Tria Health Pharmacy Advocate Program Works

Upon enrolling, your Tria Health pharmacist will schedule a one-on-one confidential phone consultation, at no cost to you, to review all your medications, preventative services and lifestyle habits to begin helping you (and your doctor):

- Ensure your medications are working and help minimize side effects.
- Identify any medication savings opportunities. Your Tria Health pharmacist has access to the *Plan's* information and can assist you in finding clinically appropriate, lower costing medications.
- Answer any questions you may have about your health.
- Assist with any other medication-related problems you are experiencing.

The Tria Health pharmacist will reach out and coordinate any recommendations directly with your doctor(s) and pharmacy. Tria Health will schedule the phone consultations as needed to manage your medications.

You will receive a $50 Tria Health Visa Rewards Gift Card for each Tria Health pharmacist consultation you attend, up to a maximum of $150 per twelve (12) month period. You are not required to change your medications, pharmacy or doctor to receive this benefit.

In addition, if you have diabetes, you will have free access to a wireless blood glucose meter, testing strips, and mobile app designed to help better manage your diabetes.

How to Enroll in the Tria Health Pharmacy Advocate Program

You may enroll in the program by calling 1-888-799-TRIA (8742) or by visiting **www.triahealth.com/enroll**.

SECTION X—PRESCRIPTION DRUG BENEFITS

A. About Your Prescription Benefits

The Prescription Drug Benefits are separate from the Medical Benefits and are administered by CVS/Caremark, the claims and appeals fiduciary for the Prescription Drug Benefits. This program allows you to use your *identification card* at a nationwide *network* of participating *pharmacies* to purchase your prescriptions. When purchasing *prescription drugs* at retail *pharmacies* or through mail-order, using your *prescription drug* card at participating *pharmacies* provides you with the best economic benefit.

Prescription drugs purchased from an *out-of-network pharmacy* are not covered.

In certain cases, you may need to request reimbursement for prescriptions that you have filled and paid for yourself. *Claims* for reimbursement of *prescription drugs* are to be submitted to the Pharmacy Benefits Manager at the address listed in the Quick Reference Information Chart.

B. Copayments

The *copayment* is applied to each covered *pharmacy* drug or mail order drug charge and is shown in the Schedule of Prescription Drug Benefits – PPO Option. The *copayment* does not apply to the Medical *Plan* annual *deductible*. The *copayment* does apply to the Medical *Plan out-of-pocket limit*.

C. Coinsurance

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

D. Manufacturer Coupons

Any amounts in the form of manufacturer coupons or drug savings discount cards do not apply to the *deductible* or *out-of-pocket limit*.

E. Mail Order Drug Benefit Option

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

F. Coverage for Infertility Drugs

CVS/Caremark provides an unlimited fertility drug benefit subject to all the plan's applicable benefits for those members in a SMART Cycle through Progyny. Medications are dispensed by CVS/Caremark.

All fertility drugs are covered, however, Progyny activation/participation is required.

G. Specialty Pharmacy Program

CVS/specialty Pharmacy, a *designated dispensing entity*, is the preferred specialty *pharmacy* provider for the *Plan*. A list of medications that must be dispensed by CVS/specialty Pharmacy is included in the following link:

www.MyAmeriBen.com

The above-referenced list is subject to change. Please call 1-888-265-7790 for the most current list of covered Specialty Medications that must be dispensed by the CVS/specialty Pharmacy. *Plan participants* will be referred to the manufacturer's designated specialty pharmacy provider for limited distribution drugs (i.e., specialty medications listed that are not currently available through CVS/specialty Pharmacy).

In general, the drugs on this list will not be covered by any *pharmacy* except for CVS/specialty Pharmacy, regardless of their *medical necessity*, approval, or if the *plan participant* has a prescription by a *physician* or

other provider. In limited circumstances, however, coverage may be allowed through an alternate provider. Those circumstances include:

1. Specialty medications billed by a facility as part of an inpatient hospital stay.*
2. Specialty medications billed as part of an emergency room visit.*
3. Situations where Medicare is the primary carrier.*
4. Limited distribution specialty medications where CVS/specialty does not have access to the drug.*
5. Circumstances where homecare is not clinically appropriate (either due to the *plan participant*'s clinical history or due to characteristics of the drug which require special handling) and an alternative infusion site (that is qualified to administer the drug) is not available for coordination of services within a reasonable proximity [thirty (30) miles or less].**
6. The treating *physician* has provided written documentation outlining the clinical rationale for the requirement that the *plan participant* be treated at the designated facility and confirming that the designated facility is unable to accept drug dispensed by CVS/specialty Pharmacy. The written documentation will be reviewed and approved by appropriate CVS/ clinical personnel before allowing coverage for the requesting provider under the medical benefit.**

*Prior approval by CVS/specialty is not required.

**Situation will be evaluated by CVS/specialty clinical staff.

Select specialty medications will be covered only under the Prescription Drug Benefits through CVS/specialty Pharmacy. As part of this policy, these Specialty Medications will be excluded from coverage under the Medical Plan.

Prior authorization and specialty preferred drug plan design management may also be required regardless of the benefit under which the drug is covered or the identity of the provider who is administering the drug.

For specialty medications listed that are not currently available through CVS/specialty Pharmacy (i.e., limited distribution drugs), *Plan participants* will be referred to the manufacturer's designated specialty pharmacy provider for distribution.

In addition, for designated specialty medications where coverage is still allowed under the Medical Plan, the drug, drug dosage(s) and site(s) of care for infusion therapy may require prior authorization for *medical necessity*, appropriates of therapy, and patient safety. Please refer to the Medical Plan for more information, including for what is and is not covered under the Medical Plan.

Notwithstanding anything to the contrary herein, any claims and appeals for Specialty Medications or Specialty Drugs must be administered under the Prescription Drug Benefits under the Plan and the applicable coverage and claims guidelines of the claims administrator (CVS/Caremark) for the Prescription Drug Benefits will be applied.

Infusion Nursing and Site of Care Management for Specialty Medications

Infusion nursing services for select specialty medications that are administered in the home and/or in an ambulatory infusion center are covered through the Prescription Drug Benefits and are coordinated through and dispensed by the CVS/specialty Pharmacy. For non-oncology infused specialty medications that require administration by a medical professional, a CareTeam nurse will work with you and your provider to assess your clinical history and determine clinically appropriate options (location for your infusion) for clinician-infused specialty medications. Options may include homecare, an ambulatory infusion center, *physician's* office, etc. CareTeam nurses will contact all impacted *plan participants* to provide assistance and guidance.

Site of Care is unavailable for drugs on the Specialty Medications list.

H. Prior Authorization

Prescriptions for certain medications or circumstances require clinical approval before they can be filled, even with a valid prescription. Prescriptions may be limited to quantity, frequency, dosage, or may have age restrictions. The authorization process may be initiated by the *plan participant*, the local *pharmacy*, or the *physician* by calling 1-800-294-5979.

I. Step Therapy Program

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

J. Covered Prescription Drug Charges

1. **Compounded Prescription Drugs.** All compounded *prescription drugs* containing at least one (1) prescription ingredient in a therapeutic quantity.

   For compound drugs to be covered under the *Plan*, they must satisfy certain requirements. In addition to being *medically necessary* and not *experimental/investigational*, compound drugs must not contain any ingredient on a list of excluded ingredients. Certain compound medications require prior authorization.

2. **Diabetic.** Insulin and other diabetic supplies when prescribed by a *physician*.

3. **Injectable Drugs.** Specialty injectable drugs covered if on the specialty list. All other injectable drugs are not covered.

4. **Prescribed by Physician.** All drugs prescribed by a *physician* that require a prescription either by federal or state law.

   This excludes any drugs stated as not covered under this *Plan*.

5. **Prescription Drugs mandated under PPACA.** Certain preventive medications (including contraceptives) received by an *in-network pharmacy* are covered and subject to the following limitations:

   a. generic preventive *prescription drugs* are covered at 100%, and the *deductible/copayment* (if applicable) is waived

   b. if no *generic drug* is available, then the *brand* will be covered at 100%, and the *deductible/copayment/coinsurance* (if applicable) is waived

   This provision includes, but is not limited to, the following categories of drugs (In order for these medications to be covered at 100%, a prescription is required from your *physician*, including over-the-counter drugs.):

   i. **Breast Cancer Risk-Reducing Medications.** Medications such as tamoxifen or raloxifene for women who are at increased risk for breast cancer and at low risk for adverse medication effects.

   ii. **Contraceptives**. Women's contraceptives including, but not limited to, oral contraceptives, transdermal contraceptives (i.e., Ortho-Evra), vaginal rings (i.e., Nuvaring), implantable contraceptive devices, injectable contraceptives, and emergency contraception.

   iii. **Tobacco Cessation Products**. Such as nicotine gum, smoking deterrent patches, or generic tobacco cessation medications. These drugs are payable without cost sharing up to 168 day supply per *calendar year*, which applies to all products. Thereafter, the applicable *copayment/coinsurance* applies.

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

   Please refer to the following website for information on the types of payable preventive medications: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or

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

6. **Vaccinations.** Certain vaccinations are available without cost sharing when mandated under PPACA.

K. Limits to This Benefit

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

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

Prescription drugs purchased from a *non-network* pharmacy or a *network* pharmacy when the *plan participant's* ID card is not used are not covered.

L. Dispense As Written (DAW) Program

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

M. Prescription Drug Plan Exclusions

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

1. **Abortifacient.**
2. **Administration.** Any charge for the administration of a covered *prescription drug*.
3. **Allergy Serums.**
4. **Blood Serum (i.e., albumin, plasma).**
5. **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
6. **COVID-19 Home Tests.** Over-the-counter (OTC) tests for COVID-19.
7. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
8. **Drugs Used for Cosmetic Purposes.** Drugs used for cosmetic purposes including hair loss drugs, anti-wrinkle creams, hair D 181 D removal creams and others (includes Botox Cosmetic & Dysport).
9. **Experimental/Investigational.** E*xperimental/investigational* drugs and medicines, even though a charge is made to the *plan participant*. A drug or medicine labeled: "Caution: Federal law prohibits dispensing without prescription."
10. **FDA.** Any drug not approved by the Food and Drug Administration.
11. **Growth Hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.
12. **Inpatient Medication.** A drug or medicine that is to be taken by the *plan participant*, in whole or in part, while *hospital* confined. This includes being confined in any *institution* that has a facility for the dispensing of drugs and medicines on its premises.
13. **Medical Exclusions.** A charge excluded under the Medical Plan Exclusions subsection, unless specifically covered in this **Prescription Drug Benefits** section.

14. **No Charge.** A charge for *prescription drugs* which may be properly received without charge under local, state, or federal programs.
15. **Non-Legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
16. **Over-the-Counter.** Any over-the-counter medicine, unless specified otherwise.
17. **Refills.** Any refill that is requested more than one (1) year after the prescription was written or any refill that is more than the number of refills ordered by the *physician*.
18. **Roctavian.**
19. **Syringes.** A charge for hypodermic syringes and/or needles, (other than for insulin).
20. **Topical Analgesics.** Topical analgesics (patches/lotions/creams) containing ingredients (alone or In combination) In strengths typically used In over-the-counter analgesics for temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness.

SECTION XI—CLAIMS AND APPEALS

This section contains the *claims* and *appeals* procedures and requirements for the *Plan*.

TIME LIMIT FOR FILING CLAIMS

All *claims* must be received by the *Plan* within twelve (12) months from the date of incurring the expense, or in accordance with applicable federal government regulations. The *Plan* will accept *network* adjustments of *claims* that are within the *network's* established guidelines.

The *Plan's* representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit *claim* determinations are made in accordance with governing plan documents and that where appropriate, the *Plan* provisions have been applied consistently with respect to similarly situated *claimants*.

The following types of *claims* are covered by the procedures in this section:

1. **Pre-Service Claim.** Some *Plan* benefits are payable without a financial penalty only if the *Plan* approves services **before** services are rendered. These benefits are referred to as *pre-service claims* (also known as *pre-certification* or prior authorization). The services that require *pre-certification* are listed in the **Health Care Management Program** section of this document.
2. **Urgent Care Claim.** An *urgent care claim* is a *claim* (request) for medical care or treatment in which:
    a. applying the time periods for *pre-certification* could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function
    b. in the opinion of a *physician* with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*
    c. the *claim* involves urgent care
3. **Concurrent Care Claim.** A *concurrent care claim* refers to a *Plan* decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A *concurrent care claim* also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.
4. **Post-Service Claim.** *Post-service claims* are *claims* that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard *claim* and an electronic bill, submitted for payment after services have been provided, are examples of *post-service claims*. A *claim* regarding rescission of coverage will be treated as *post-service claim*.

Following is a description of how the *Plan* processes *claims* for benefits and reviews the *appeal* of any *claim* that is denied.

If a *claim* is denied, in whole or in part, or if *Plan* coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an *adverse benefit determination*.

A *claimant* has the right to request a review of an *adverse benefit determination*. This request is an *appeal*. If the *claim* is denied at the end of the *appeal* process, as described later in this section, the *Claim Administrator's* final decision is known as a *final internal adverse benefit determination*. If the *claimant* receives *notice* of a *final internal adverse benefit determination*, or if the *Plan* does not follow the *appeal* procedures properly, the *claimant* then has the right to request an independent *external review*. The *external review* procedures are also described later in this section.

Both the *claims* and the *appeal* procedures are intended to provide a full and fair review. This means, among other things, that *claims* and *appeals* will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A *claimant* must follow all *claims* and *appeals* procedures, both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the *Claim Administrator* has not complied with the procedures described in this section. If a lawsuit is brought, it must be filed within one (1) year after the final determination of an *appeal*.

Any of the authority and responsibilities of the *Claim Administrator* under the *claims* and *appeals* procedures or the *external review* process, including the discretionary authority to interpret the terms of the *Plan*, may be

delegated to a third party. If you have any questions regarding these procedures, please contact the *Claim Administrator*.

A. Timeframes for Claim and Appeal Processes

	Post-Service Claims	Pre-Service Claim Types		
		Urgent Care Claim	Concurrent Care Claim	Other Pre-Service Claim
Claimant must submit *claim* for benefit determination within:	twelve (12) months	twenty-four (24) hours		
Plan must make initial *benefit determination* as soon as possible but no later than:	thirty (30) days	seventy-two (72) hours	Before the benefit is reduced or treatment terminated	fifteen (15) days
Extension permitted during initial *benefit determination*:	fifteen (15) days	No	No	fifteen (15) days
First-level *appeal* review must be submitted to the *Plan* within:	one hundred eighty (180) days	one hundred eighty (180) days	one hundred eighty (180) days	one hundred eighty (180) days
Plan must make first *appeal benefit determination* as soon as possible but no later than:	thirty (30) days	thirty-six (36) hours	Before the benefit is reduced or treatment terminated	fifteen (15) days
Extension permitted during *appeal* review:	No	No	No	No
Second-level appeal must be submitted in writing within:	sixty (60) days	sixty (60) days	sixty (60) days	sixty (60) days
Plan must make second *appeal benefit determination* as soon as possible but no later than:	thirty (30) days	36 hours	thirty (30) days	thirty (30) days
Appeal for external review must be submitted after a final adverse benefit determination within:	four (4) months	four (4) months	four (4) months	four (4) months
Plan will complete preliminary review of *IRO* request within:	five (5) business days	five (5) business days	five (5) business days	five (5) business days
Plan will notify *claimant* of preliminary review within:	one (1) business day	one (1) business day	one (1) business day	one (1) business day
IRO determination and notice within:	forty-five (45) days	seventy-two (72) hours	seventy-two (72) hours	forty-five (45) days

B. Types of Claims Managed by the Medical Management Administrator

The following types of *claims* are managed by the *Medical Management Administrator*:

1. *urgent care claims*
2. *concurrent care claims*
3. other *pre-service claims*

The process and procedures for each *pre-service claim* type are listed below.

C. Urgent Care Claims

Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an *urgent care claim* will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any *claim* that a *physician,* with knowledge of the *claimant's* medical condition, determines is an *urgent care claim* (as described herein) shall be treated as an *urgent care claim* under the *Plan*. *Urgent care claims* are a subset of *pre-service claims*.

How to File Urgent Care Claims

In order to file an *urgent care claim*, you or your *authorized representative* must call the *Medical Management Administrator* and provide the following:

1. information sufficient to determine whether, or to what extent, benefits are covered under the *Plan*
2. a description of the medical circumstances that give rise to the need for expedited review

If you or your *authorized representative* fail to provide the *Plan* with the above information, the *Plan* will provide *notice* as soon as reasonably possible after receipt of your *claim*, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes. You will be afforded a reasonable amount of time to provide the specified information under the circumstance, but no less than within the timeframe shown in the Timeframes for Claim and Appeal Processes.

Notification of Benefit Determination of Urgent Care Claims

Notice of a *benefit determination* (whether adverse or not) will be provided as soon as possible, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the *claim*. However, if the *Plan* gives you *notice* of an incomplete *claim*, the *notice* will include a time period of no less than forty-eight (48) hours for you to respond with the requested specified information. The *Plan* will then provide you with the *notice* of *benefit determination* within forty-eight (48) hours after the earlier of:

1. receipt of the specified information
2. the end of the period of time given you to provide the information

If the *benefit determination* is provided orally, it will be followed in writing no later than three (3) days after the oral *notice*.

If the *urgent care claim* involves a concurrent care decision, a *notice* of the *benefit determination* (whether adverse or not) will be provided as soon as possible, but no later than twenty-four (24) hours after receipt of your *claim* for extension of treatment or care, as long as the *claim* is made at least twenty-four (24) hours before the prescribed period of time expires or the prescribed number of treatments ends.

Notification of Adverse Benefit Determination of Urgent Care Claims

If an *urgent care claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Claim Administrator's notification* of an *adverse benefit determination* may be oral, followed by written or electronic *notification* within three (3) days of the oral *notification*. The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination,* either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the expedited review process applicable to the *claim*

8. a description of the *Plan's* review or *appeal* procedures, including applicable time limits, and a statement of your right to bring suit under *ERISA* §502(a) with respect to any *claim* denied after an *appeal*
9. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of an Urgent Care Claim

You may *appeal* any *adverse benefit determination* to the *Plan Appointed Claim Evaluator* (*PACE*). The *PACE* is the appeals fiduciary of the *Plan* for appeals and exercises discretionary authority and control over the administration of such benefits under the *Plan* and has discretionary authority to determine eligibility for such *Plan* benefits and to construe the terms of the *Plan*. With respect to the Prescription Drug Benefits under the Plan, CVS/Caremark is the appeals fiduciary for appeals and exercises discretionary authority and control over the administration of such benefits under the Plan and has discretionary authority to determine eligibility for such Plan benefits and to construe the terms of the Plan. With respect to such Prescription Drug Benefits, any references to PACE in the appeals procedures below will be read as referring to CVS/Caremark. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes for when a *claimant* may file a written request for an *appeal* to the decision upon *notification* of an *adverse benefit determination*, the *claimant* generally has **one hundred eighty (180) days** following receipt of the *notification* in which to file a written request for an *appeal* of the decision. However, for *concurrent care claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within the timeframe shown in the Timeframes for Claim and Appeal Processes. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *PACE* or its designee will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *PACE* or its designee written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *PACE* or its designee will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *PACE* or its designee issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *PACE* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of Appeals of Denied Urgent Care Claims

You or your *authorized representative* must file an *appeal* of an *adverse benefit determination* after receiving notification of the *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection.

Requests for *appeal* which do not comply with the above requirement will not be considered.

You may *appeal* an *adverse benefit determination* of an *urgent care claim* on an expedited basis, either orally or in writing. You may *appeal* orally by calling the *Medical Management Administrator*. All necessary information, including the *Medical Management Administrator's benefit determination* on review, will be transmitted between the *Medical Management Administrator* and you by telephone, facsimile, or other available similarly expeditious method.

Time Period for Deciding Appeals of Urgent Care Claims

Appeals of *urgent care claims* will be decided by the *PACE* or its designee as soon as possible after the *Plan Administrator* or its designee receives the *appeal*, taking into account the *medical emergencies*, but no later the timeframe shown in the Timeframes for Claim and Appeal Processes. A decision communicated orally will be followed-up in writing.

Notification of Appeal Denials of Urgent Care Claims

The *PACE* or its designee shall provide *notification* of the decision on an *urgent care claim* orally, but a follow-up written *notification* will be provided after the oral *notice* no later than than the timeframe shown in the Timeframes for Claim and Appeal Processes. The *notice* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *PACE's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational*, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request
7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures, and a statement of your right to bring suit under *ERISA* §502(a)
10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

D. Concurrent Care Claims

Your *claim* for medical care or treatment is a *concurrent care claim* if your *claim* has been approved to provide an ongoing course of treatment over a period of time, which either involves a reduction or termination by the *Claim Administrator* of such course of treatment (other than by *Plan* amendment or termination), or a request by you or on your behalf to extend or expand your treatment.

If your request involves concurrent care (the continuation/reduction of an ongoing course of treatment), you may file the *claim* by writing (orally for an expedited review) to the *Medical Management Administrator*.

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided *notification* of the termination or reduction sufficiently in advance of the reduction or termination to allow you to *appeal* and obtain a determination of that *adverse benefit determination* before the benefit is reduced or terminated.
2. The *Claim Administrator* will provide you free of charge with any new or additional evidence considered, relied upon, or generated by the *Plan* (or at the direction of the *Plan*) in connection with the denied *claim*. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the *notice* of *adverse benefit determination* on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the *Claim Administrator* issues an *adverse benefit determination* or review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the *notice* of *adverse benefit determination* on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
3. A *concurrent care claim* that involves urgent care will be processed according to the initial review and *appeals* procedures and timeframes noted under the Urgent Care Claims subsection (above).
4. If a *concurrent care claim* does not involve urgent care, the request may be treated as a new benefit *claim* and decided within the timeframe appropriate to the type of *claim* (i.e., as a *pre-service claim* or a *post-service claim*). Such *claims* will be processed according to the initial review and *appeals* procedures and timeframes applicable to the claim-type, as noted under the Other Pre-Service Claims subsection (below) or the Post-Service Claims subsection listed later in this section.
5. If the *concurrent care claim* is approved, you will be *notified* orally followed by written (or electronic, as applicable) *notice* provided after the oral *notice* no later than the timeframe shown in the Timeframes for Claim and Appeal Processes

E. Other Pre-Service Claims

Claims that require *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* are considered *other pre-service claims* (e.g. a request for *pre-certification* under the Health Care Management Program). Refer to the **Heath Care Management Program** section to review the list of services that require *pre-certification*.

How to File Other Pre-Service Claims

Typically, *other pre-service claims* are made on a *claimant's* behalf by the treating *physician*. However, it is the *claimant's* responsibility to ensure that the *other pre-service claim* has been filed. The *claimant* can accomplish this by having his or her *health care provider* contact the *Medical Management Administrator* to file the *other pre-service claim* on behalf of the *claimant*.

Other pre-service claims must *include* the following information:

1. the name of this *Plan*
2. the identity of the *claimant* (name, address, and date of birth)
3. the proposed date(s) of service
4. the name and credentials of the *health care provider*
5. an order or request from the *health care provider* for the requested service

6. the proposed place of service
7. a specific diagnosis
8. a specific proposed service code for which approval or payment is requested [current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format]
9. clinical information for this *Plan* to make a *medical necessity* determination

Under certain circumstances provided by federal law, if you or your *authorized representative* fail to follow the *Plan's* procedures for filing *other pre-service claims*, the *Claim Administrator* will provide *notice* of the failure and the proper procedures to be followed. This *notification* will be provided as soon as reasonably possible, but no later than five (5) days after receipt of the *claim*. You will then have up to forty-five (45) days from receipt of the *notice* to follow the proper procedures.

Notification of Benefit Determination of Other Pre-Service Claims

After receipt of the *claim, notice* of a *benefit determination* (whether adverse or not) will be provided in writing within a reasonable period appropriate to the medical circumstances, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes. However, this period may be extended one (1) time by the *Claim Administrator* for up to the timeframe shown in the Timeframes for Claim and Appeal Processes if the *Claim Administrator* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original time period, of the circumstances requiring the extension and the date by which the *Claim Administrator* expects to render a decision. Refer to the Incomplete Claims subsection, if such an extension is necessary due to your failure to submit the information necessary to decide the *claim*.

Notification of Adverse Benefit Determination of Other Pre-Service Claims

If the *other pre-service claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Claim Administrator* or its designee shall provide written or electronic *notification* of the *adverse benefit determination*. This *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Claim Administrator's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination,* either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the *Plan's* review or *appeal* procedures, including applicable time limits, and a statement of your right to bring suit under *ERISA* §502(a) with respect to any *claim* denied after an *appeal*
8. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of Other Pre-Service Claims

You may *appeal* any *adverse benefit determination* to the *PACE*. The *PACE* is the appeals fiduciary of the *Plan* and exercises discretionary authority and control over the administration of the *Plan* and has discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes in which a *claimant* may file a written request for an *appeal* of the decision after receiving *notification* of an *adverse benefit determination*. However, for *concurrent care claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within thirty (30) days. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *PACE* or its designee will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s), and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *PACE* or its designee written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *PACE* or its designee will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *PACE* or its designee issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *PACE* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of Appeals of Denied Other-Pre-Service Claims

You or your *authorized representative* must file an *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes after receiving *notification* of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirement will not be considered.

All requests for a review of a denied *pre-service claim* (other than *urgent care claim*) must be in writing and should include a copy of the *adverse benefit determination*, if applicable, and any other pertinent information that you wish the *Medical Management Administrator* to review in conjunction with your *appeal*. Send all information to the *Medical Management Administrator* as listed in the Quick Reference Information Chart.

Time Period for Deciding Appeals of Other Pre-Service Claims

Appeals of other *pre-service claims* will be decided by the *PACE* or its designee within a reasonable period of time appropriate to the medical circumstances, after the *Plan Administrator* or its designee receives the *appeal,* but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes. The *PACE's* decision will be provided to you in writing.

Notification of Appeal Denials of Other Pre-Service Claims

If your *appeal* is denied, in whole or in part, the *PACE* or its designee will provide written *notification* of the *adverse benefit determination* on *appeal*. The *notice* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *PACE's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity, experimental/investigational,* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request
7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures, and a statement of your right to bring suit under *ERISA* §502(a)
10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

F. Second Level Appeals Process for Urgent Care, Concurrent Care, and Other Pre-Service Claims

If your *appeal* of a *claim* is denied, you or your *authorized representative* may request further review by the *PACE*. This request for a second-level *appeal* must be made in writing within the timeframe shown in the Timeframes for Claim and Appeal Processes. This second-level review is mandatory; i.e., you are required to undertake this second-level *appeal* before you may pursue civil action under Section 502(a) of *ERISA*.

The *PACE* or its designee will promptly conduct a full and fair review of your *appeal*, independently from the individual(s) who considered your first-level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *PACE* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the *adverse benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

Second-level *appeals* of *claims* will be decided by the *PACE* or its designee within a reasonable period of time after the *Plan Administrator* or its designee receives the *appeal*, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes. The *PACE* or its designee's decision will be provided to you in writing, and if the decision is a second denial, the *notification* will include all of the information described in the subsection entitled Notification of Appeal Denials above.

G. External Review of Pre-Service Claims

Refer to the **External Review of Claims** section for the full description of the external review process under the *Plan*.

H. Incomplete Claims

Incomplete *pre-service claims* and/or *post-service claims* can be addressed through the extension of time described herein. (Refer to *Clean Claim* in the **Defined Terms** section.) If the reason for the extension is the failure to provide necessary information and the *claimant* is appropriately *notified*, this *Plan's* period of time to make a decision is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the *claimant* responds or should have responded.

The *notification* will include a timeframe of at least forty-five (45) days in which the necessary information must be provided. Once the necessary information has been provided, the *Claim Administrator* will decide the *claim* within the extension described herein.

However, if the time period for the *benefit determination* is extended due to your failure to submit information necessary to decide a *claim*, the time period for making the *benefit determination* will be suspended from the date the *notice* of extension is sent to you until the earlier of:

1. the date on which you respond to the request for additional information
2. forty-five (45) days

If the requested information is not provided within the time specified, the *claim* may be denied. If your *claim* is denied based on your failure to submit information necessary to decide the *claim*, the *Claim Administrator* may, in its discretion, renew its consideration of the denied *claim* if the *Claim Administrator* receives the additional information within one hundred eighty (180) days after original receipt of the *claim*. In such circumstances, you will be *notified* of the *Claim Administrator's* reconsideration and subsequent *benefit determination*.

I. Post-Service Claims

The *Claim Administrator* manages the *claims* of *post-service claims*.

Post-service claims are *claims* that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard *claim* and an electronic bill, submitted for payment after services have been provided, are examples of *post-service claims*. A *claim* regarding rescission of coverage will be treated as a *post-service claim*.

How to File Post-Service Claims

In order to file a *post-service claim*, you or your *authorized representative* must submit the *claim* in writing on a form pre-approved by the *Plan*. Pre-approved *claim* forms are available from the *Claim Administrator*.

All *claims* must be received by the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes from the date of incurring the expense and must include the following information:

1. the *plan participant's* name, Social Security Number, and address

2. the covered *employee's* name, Social Security Number, and address if different from the *plan participant's*
3. the provider's name, tax identification number, address, degree, and signature
4. date(s) of service
5. diagnosis
6. procedure codes (describes the treatment or services rendered)
7. *assignment of benefits*, signed by the *participant* (solely for purposes of making direct payment to the provider)
8. release of information statement, signed
9. coordination of benefits (COB) information if another plan is the primary payer
10. sufficient medical information to determine whether and to what extent the expense is a covered benefit under the *Plan*

Send complete information to:

AmeriBen
P.O. Box 7186
Boise, ID 83707

Notification of Benefit Determination of Post-Service Claims

After receipt of the *claim*, the *Claim Administrator* will *notify* you or your *authorized representative* of its *benefit determination* (whether adverse or not) no later than the timeframe shown in the Timeframes for Claim and Appeal Processes. However, this period may be extended one (1) time by the *Claim Administrator* for up to the timeframe shown in the Timeframes for Claim and Appeal Processes if the *Claim Administrator* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original period, of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision.

The applicable time period for the *benefit determination* begins when your *claim* is filed in accordance with the reasonable procedures of the *Plan*, even if you haven't submitted all the information necessary to make a *benefit determination*. Refer to the Incomplete Claims subsection for information regarding incomplete *claims*.

Notification of Adverse Benefit Determination of Post-Service Claims

If a *post-service claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Claim Administrator* or its designee shall provide written or electronic *notification* of the *adverse benefit determination*. This *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Claim Administrator's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination,* either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request

7. a description of the *Plan's* review or *appeal* procedures, including applicable time limits, and a statement of your right to bring suit under *ERISA* §502(a) with respect to any *claim* denied after an *appeal*
8. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

Two Levels of Internal Appeal of Post-Service Claims

The *Plan* requires two levels of *appeal* by a *claimant* before the *Plan's* internal *appeals* are exhausted. For each level of *appeal*, the *claimant* and the *Plan* are subject to the same procedures, rights, and responsibilities as stated within this *Plan*. Each level of *appeal* is subject to the same submission and response guidelines, except where two levels of internal *appeal* are applied, then the *PACE* or its designee shall notify the *claimant* of the *Plan's benefit determination* no later than thirty (30) days following the receipt of each internal *appeal*.

Once a *claimant* receives an *adverse benefit determination* in response to an initial *claim* for benefits, the *claimant* may appeal that *adverse benefit determination*, which will constitute the first-level *appeal*. If the *claimant* receives an *adverse benefit determination* in response to that first-level *appeal*, the *claimant* may appeal that *adverse benefit determination* as well, which will constitute the final internal *appeal*. If the *claimant* receives an *adverse benefit determination* in response to the *claimant's* second-level *appeal*, such *adverse benefit determination* will constitute the final *adverse benefit determination*, and the Plan's internal *appeals* procedures will have been exhausted.

How to File an Appeal of Post-Service Claims

You may *appeal* any *adverse benefit determination* to the *PACE*. The *PACE* is an appeals fiduciary of the *Plan* and exercises discretionary authority and control over the administration of the *Plan* and has discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes in which a *claimant* may file a written request for an *appeal* of the decision. However, for *concurrent care claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within the timeframe shown in the Timeframes for Claim and Appeal Processes after receipt of notification of such rescission of coverage. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *PACE* or its designee will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *PACE* or its designee written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *PACE* or its designee will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *PACE* or its designee issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *PACE* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of Appeals of Denied Post-Service Claims

You or your *authorized representative* must file an *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes after receiving *notification* of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirement will not be considered.

All requests for a review of a denied *post-service claim* must be in writing and should include a copy of the *adverse benefit determination* and any other pertinent information that you wish the *PACE* to review in conjunction with your *appeal*. Send all information to:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707

Time Period for Deciding Appeals of Post-Service Claims

Appeals of *post-service claims* will be decided by the *PACE* or its designee within a reasonable period of time, but no later than after the *Plan Administrator* or its designee receives the *appeal*, but not later than the timeframe shown in the Timeframes for Claim and Appeal Processes. The *PACE* or its designee's decision will be provided to you in writing.

Notification of Appeal Denials of Post-Service Claims

If your *appeal* is denied, in whole or in part, the *PACE* or its designee will provide written *notification* of the *adverse benefit determination* on *appeal*. The *notice* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational*, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request
7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary

8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures, and a statement of your right to bring suit under *ERISA* §502(a)
10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

J. Second-Level Appeal Process of Post-Service Claims

The *Plan Appointed Claim Evaluator* or *PACE* manages the second-level *appeal* process for *post-service claim decisions* (*final post-service appeals*).

The *PACE* or its designee will be identified in the *notification* of denial of your first-level *appeal* and will not be the individual who made the original decision regarding the denial of your first-level *appeal* or a subordinate of such individual.

If your *appeal* of a *post-service claim* is denied, you or your *authorized representative* may request further review by the *PACE*. This request for a second-level *appeal* must be made in writing within the timeframe shown in the Timeframes for Claim and Appeal Processes. For *claims*, this second-level review is mandatory; i.e., you are required to undertake this second-level *appeal* before you may pursue civil action under Section 502(a) of *ERISA*.

The *PACE* or its designee will promptly conduct a full and fair review of your *final post-service appeal*, independently from the individual(s) who considered your first-level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information, as described in more detail under the subsection entitled Post-Service Claims above.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *PACE* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the *adverse benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

A *final post-service appeal* will be decided by the *PACE* or its designee within a reasonable period of time, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes. The *PACE's* decision will be provided to you in writing and the *notification* will include all of the information described in the provision entitled Notification of Appeal Denials of Post-Service Claims above.

Upon receipt, review, adjudication and conclusion of a *final post-service appeal*, if it is determined by the *PACE* that benefits and/or coverage are not available from the *Plan* as they relate to *claims* for benefits submitted to the *Plan*, the determination will be final and binding on all interested parties.

The *PACE* shall at all times strictly abide by, and make determination(s) in accordance with, the terms of the *Plan* and applicable law. With respect to the processing of *final post-service appeals* only, the *PACE* shall have sole, full and final discretionary authority to interpret all *Plan* provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the *Plan* and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a *participant's* rights; and to determine all questions of fact and law arising under the *Plan*. In such instances, the *PACE's* determinations will be final and binding on all interested parties, including the *participant*, *Plan Administrator*, *Plan Sponsor* and/or any other fiduciary appointed to act on behalf of the *Plan*.

K. Requirements for Second Level Appeal

The *claimant* must file an *appeal* regarding a post-service *claim* and applicable *adverse benefit determination*, in writing within thirty (30) days following receipt of the notice of the first level *adverse benefit determination*.

L. Two Levels of Appeal

This *Plan* requires two levels of *appeal* by a *claimant* before the *Plan's* internal appeals are exhausted. For each level of *appeal*, the *claimant* and the *Plan* are subject to the same procedures, rights, and responsibilities as stated within this *Plan*. Each level of *appeal* is subject to the same submission and response guidelines.

Once a *claimant* receives an *adverse benefit determination* in response to an initial *claim* for benefits, the *claimant* may appeal that *adverse benefit determination*, which will constitute the initial *appeal*. If the *claimant* receives an *adverse benefit determination* in response to that initial *appeal*, the *claimant* may appeal that *adverse benefit determination* as well, which will constitute the final internal *appeal*. If the *claimant* receives an *adverse benefit determination* in response to the *claimant's* second *appeal*, such *adverse benefit determination* will constitute the *final internal adverse benefit determination*, and the Plan's internal appeals procedures will have been exhausted.

M. Final Internal Adverse Benefit Determination

Upon receipt, review, adjudication and conclusion of a *final post-service appeal*, if it is determined by the *Plan* fiduciary – either the *Plan Administrator*, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, or the *PACE* – that benefits and/or coverage is not available from the *Plan* as it relates to *claims* for benefits submitted to the *Plan*; when such a *final adverse benefit determination* is made, by either the *Plan Administrator*, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, or the *PACE*, the determination will be final and binding on all interested parties.

N. External Review Rights

If your *Final Post-Service Appeal* is denied, you will be *notified* in writing that your *claim* is eligible for an *external review*, and you will be informed of the timeframes and the steps necessary to request an *external review*. You must complete all levels of the internal *claims* and *appeals* procedures before you can request a voluntary *external review*. In addition, *external review* is only available in certain circumstances as described below in the section External Review of Claims.

If you decide to seek *external review*, an *independent review organization* (*IRO*) will be assigned your *claim*, and the *IRO* will work with a neutral, independent clinical reviewer with appropriate medical expertise. The *IRO* does not have to give deference to any earlier *claims* and *appeals* decisions, but it must observe the written terms of the plan document. In other words, the *IRO* is not bound by any previous decision made on your *claim*. The ultimate decision of the *IRO* will be binding on you, *PACE,* the *Claim Administrator*, and the *Plan*.

O. External Review of Claims

The *external review* process is available only where the *final internal adverse benefit determination* is denied on the basis of any of the following:

1. a medical judgment (which includes but is not limited to: *Plan* requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit)
2. a determination that a treatment is *experimental* or *investigational*
3. a rescission of coverage

If your *appeal* is denied, you or your *authorized representative* may request further review by an *independent review organization* (*IRO*). This request for *external review* must be made, in writing, within the timeframe shown in the Timeframes for Claim and Appeal Processes of the date you are notified of an *adverse benefit determination* or *final internal adverse benefit determination*. This *external review* is mandatory; i.e., you are required to undertake this *external review* before you may pursue civil action under Section 502(a) of *ERISA*.

The date of receipt of the *external review* request, the *Claim Administrator* will complete a preliminary review within the timeframe shown in the Timeframes for Claim and Appeal Processes following the date of receipt of the *external review* request of the request to determine whether:

1. the *claimant* is or was covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the *Plan* at the time the health care item or service was provided

2. the *adverse benefit determination* or the *final internal adverse benefit determination* does not relate to the *claimant's* failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination)
3. the *claimant* has exhausted the *Plan's* internal *appeal* process
4. the *claimant* has provided all the information and forms required to process an *external review*

The *Claim Administrator* will notify the *claimant* within the timeframe shown in the Timeframes for Claim and Appeal Processes following the date of the receipt of the *external review* request of completion of its preliminary review if either:

1. the request is complete but not eligible for *external review*, in which case the *notice* will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration [toll-free number 1-866-444-EBSA (3272)]
2. the request is not complete, in which case the *notice* will describe the information or materials needed to make the request complete, and allow the *claimant* to perfect the request for *external review* within the timeframe shown in the Timeframes for Claim and Appeal Processes, or within the forty-eight (48)-hour period following receipt of the notification, whichever is later

NOTE: If the *adverse benefit determination* or *final internal adverse benefit determination* relates to a *plan participant's* or beneficiary's failure to meet the requirements for eligibility under the terms of the *Plan*, it is not within the scope of the *external review* process, and no *external review* may be taken.

If the request is complete and eligible, the *Claim Administrator* or its designee will assign the request to an *IRO*. Once that assignment is made, the following procedure will apply:

1. The assigned *IRO* will utilize legal experts where appropriate to make coverage determinations under the *Plan*.
2. The assigned *IRO* will timely *notify* the *claimant* in writing of the request's eligibility and acceptance for *external review*. This *notice* will include a statement that the *claimant* may submit in writing to the assigned *IRO,* within ten (10) business days following the date of receipt of the *notice,* additional information that the *IRO* must consider when conducting the *external review*. The *IRO* is not required to, but may, accept and consider additional information submitted after ten (10) business days.
3. the timeframe shown in the Timeframes for Claim and Appeal Processes after the date of assignment of the *IRO*, the *Claim Administrator* must provide to the assigned *IRO* the documents and any information considered in making the *adverse benefit determination* or *final internal adverse benefit determination*. Failure by the *Claim Administrator* to timely provide the documents and information must not delay the conduct of the *external review*. If the *Claim Administrator* fails to timely provide the documents and information, the assigned *IRO* may terminate the *external review* and make a decision to the *adverse benefit determination* or *final internal adverse benefit determination*. The *IRO* must *notify* the *claimant* and the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes after making the decision.
4. Upon receipt of any information submitted by the *claimant*, the assigned *IRO* must within one (1) business day forward the information to the *Claim Administrator*. Upon receipt of any such information, the *Claim Administrator* may reconsider its *adverse benefit determination* or *final internal adverse benefit determination* that is the subject of the *external review*. Reconsideration by the *Claim Administrator* must not delay the *external review*. The *external review* may be terminated as a result of the reconsideration only if the *Claim Administrator* decides, upon completion of its reconsideration, to reverse its *adverse benefit determination* or *final internal adverse benefit determination* and provide coverage or payment. The *Claim Administrator* must provide written *notice* of its decision to the *claimant* and the assigned *IRO* within the timeframe shown in the Timeframes for Claim and Appeal Processes. The assigned *IRO* must terminate the *external review* upon receipt of the *notice* from the *Plan*.
5. The *IRO* will review all of the information and documents timely received. In reaching a decision, the assigned *IRO* will review the *claim* de novo and not be bound by any decisions or conclusions reached during the *Claim Administrator's* internal *claims* and *PACE's appeals* process. In addition to the documents and information provided, the assigned *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, will consider the following in reaching a decision:
    a. the *claimant's* medical records
    b. the attending health care professional's recommendation

c. reports from appropriate health care professionals and other documents submitted by the *Plan*, *claimant*, or the *claimant's* treating provider

d. the terms of the *claimant's Plan* to ensure that the *IRO's* decision is not contrary to the terms of the *Plan*, unless the terms are inconsistent with applicable law

e. appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations

f. any applicable clinical review criteria developed and used by the *Claim Administrator*, unless the criteria are inconsistent with the terms of the *Plan* or with applicable law

g. the opinion of the *IRO's* clinical reviewer or reviewers after considering the information described in this *notice* to the extent the information or documents are available

6. The assigned *IRO* must provide written *notice* of the final *external review* after the *IRO* receives the request for the *external review* within the timeframe shown in the Timeframes for Claim and Appeal Processes. The *IRO* must deliver the *notice* of *final external review decision* to the *claimant* and the *Claim Administrator*.

7. The assigned *IRO's* decision *notice* will contain:

a. a general description of the reason for the request for *external review*, including information sufficient to identify the *claim* [including the date or dates of service, the health care provider, the *claim* amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial]

b. the date the *IRO* received the assignment to conduct the *external review* and the date of the *IRO* decision

c. the references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision

d. a discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision

e. a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health *Plan* or to the *claimant*

f. a statement that judicial review may be available to the *claimant*

g. current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman

If you remain dissatisfied with the outcome of the *external review*, you may pursue civil action under Section 502(a) of *ERISA*.

Generally, a *claimant* must exhaust the *Plan's claims* and *appeals* procedures in order to be eligible for the *external review* process. However, in some cases the *Plan* provides for an expedited *external review* if either:

1. The *claimant* receives an *adverse benefit determination* that involves a medical condition for which the time for completion of the *Plan's* internal *claims* and *appeals* procedures would seriously jeopardize the *claimant's* life, health, or ability to regain maximum function, and the *claimant* has filed a request for an expedited internal review.

2. The *claimant* receives a *final internal adverse benefit determination* that involves a medical condition where the time for completion of a standard *external review* process would seriously jeopardize the *claimant's* life or health or the *claimant's* ability to regain maximum function, or if the *final internal adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the *claimant* received *emergency services*, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited *external review*, the *Plan* must determine and *notify* the *claimant* whether the request satisfies the requirements for expedited review, including the eligibility requirements for *external review* listed above. If the request qualifies for expedited review, it will be assigned to an *IRO*. The *IRO* must make its determination and provide a *notice* of the decision as expeditiously as the *claimant's* medical condition or circumstances require after the *IRO* receives the request for an expedited *external review*, but in no event more than the timeframe shown in the Timeframes for Claim and Appeal Processes. If the original *notice* of its decision is not in writing, the *IRO* must provide written confirmation of

the decision to both the *claimant* and the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes.

P. Appointment of Authorized Representative

A *plan participant* is permitted to appoint an *authorized representative* to act on his/her behalf with respect to a benefit *claim* or *appeal* of a denial. In connection with a *claim* involving urgent care, the *Plan* will permit a health care professional with knowledge of the *plan participant's* medical condition to act as the *plan participant's authorized representative*. In the event a *plan participant* designates an *authorized representative*, all future communications from the *Plan* will be with the representative, rather than the *plan participant*, unless the *plan participant* directs the *Plan Administrator*, in writing, to the contrary.

Q. Physical Examinations

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

R. Autopsy

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

S. Payment of Benefits

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

T. Assignments

The *Plan* contains an anti-assignment provision. This provision provides that no benefit payable at any time under the *Plan* shall be subject to anticipation, alienation, sale, assignment, transfer, pledge, encumbrance, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise. Any attempt by you (or any other person, provider or entity) to do so will be void and of no effect. None of the following shall be liable for, or subject to, any obligation or liability of any *participant* (e.g., through garnishment, attachment, pledge, or bankruptcy): the *Plan*, the *Plan Administrator*, the *Claim Administrator*, *PACE*, or the *Company*. Benefits under the Medical Benefit Option of this *Plan* may not be assigned, transferred or in any way made over to another party by a *participant*. This means that you may not assign to a medical provider (or to anyone) your rights to receive benefits under the *Plan*, or to bring a *claim* or lawsuit for benefits or for breach or violation of any other duty or obligation owed to you under the *Plan*. These rights are yours alone and may not be transferred to another party. No medical provider, or any other person or entity, is permitted to bring a *claim* against the *Plan* under ERISA or any other law through a purported assignment or similar agreement, and any attempt to assign or otherwise transfer such rights will be void and unenforceable. Nothing contained in the written description of the *Company's* Medical Benefit Option shall be construed to make the *Plan*, the *Company* or its affiliates liable to any third-party to whom a *participant* may be liable for medical care, treatment, or services.

The *Claim Administrator* for the Medical Benefit Option may elect to pay medical providers directly for covered expenses for the convenience of the *participant*. A direct payment to a medical provider at the election of the *Claim Administrator* is not an assignment of the applicable *participant's* ERISA or other legal rights under the *Plan* related to the *claim* for benefits to which the direct payment relates. The *Plan* prohibits the assignment of a *participant's* ERISA and other legal rights as described in the preceding paragraph.

U. Non-U.S. Providers

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

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

V. Recovery of Payments

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

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

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

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

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

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

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

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

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

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

SECTION XII—DEFINED TERMS

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

Accident

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

Accidental Injury (Accidental Injuries)

An objectively demonstrable impairment of bodily function caused by trauma from a sudden, unforeseen outside force or object, occurring at an identifiable time and place, and without the *plan participant's* foresight or expectation.

Acquired Brain Injury

A neurological insult to the brain, which is not hereditary, congenital, or degenerative. The *injury* to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Adoptive Cell Therapy

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

Adverse Benefit Determination

Adverse benefit determination shall mean any of the following:

1. a denial in benefits
2. failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a *claimant's* eligibility to participate in the *Plan*
3. a reduction in benefits
4. a rescission of coverage, even if the rescission does not impact a current *claim* for benefits
5. termination of benefits
6. a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review
7. a failure to cover an item or service for which benefits are otherwise provided because it is determined to be *experimental or investigational* or not *medically necessary* or appropriate

Allowable Charges

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

Ambulatory Surgical Center

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

Appeal

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

Applied Behavioral Analysis (ABA) Therapy

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

Approved Clinical Trial

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

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

Balance Bill/Surprise Bill

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

Out-of-network providers have no obligation to accept the *allowable charge* as payment in full. You are responsible to pay an *out-of-network provider's* billed charges, even though the *Plan's*

reimbursement is based on the *allowable charge*. Any amounts paid for balance bills do not count toward the *deductible*, *coinsurance*, or *out-of-pocket limit*.

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

Birthing Center

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

The birthing center must provide the following:

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

Brand Name

A trade name medication.

Calendar Year/Benefit Year

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

Cellular Immunotherapy

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

Claim

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

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

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

Claim Administrator

AmeriBen has been hired as the Claim Administrator by the *Plan Administrator* to perform *claims* processing and other specified administrative services in relation to the *Plan*. The Claim Administrator is not an insurer of health benefits under this *Plan*. However, the Claim Administrator is the *Claim Administrator*, exercising the discretionary authority and responsibility granted to the *Plan Administrator* to determine the validity of a *participant's claim* for benefits. The Claim Administrator is not responsible for *Plan* financing and does not guarantee the availability of benefits under this *Plan*.

Claimant

A *participant* of the *Plan*, or entity acting on the *participant's* behalf, authorized to submit claims to the *Plan* for processing, and/or appeal an *adverse benefit determination*.

Coinsurance

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

Company

Means Energy Transfer LP

Complications of Pregnancy

Includes both of the following:

1. Conditions (when the *pregnancy* is not terminated) whose diagnoses are distinct from *pregnancy* but are adversely affected by *pregnancy* or are caused by *pregnancy*, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of *pregnancy*, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult *pregnancy* not constituting a nosologically distinct complication of pregnancy.
2. Non-elective cesarean section, termination of ectopic *pregnancy*, and spontaneous termination of *pregnancy* occurring during a period of gestation in which a viable birth is not possible.

Consumer Driven Health Plan (CDHP)

A type of medical plan that puts *participants* in control of their health care, typically by pairing a comprehensive, higher-deductible/lower-premium plan with a tax-advantaged funding account.

Copayment

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

Cosmetic

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

Cost Sharing Amounts

The dollar amount a *plan participant* is responsible for paying when covered services are received from a provider. Cost sharing amounts include *coinsurance*, *copayments*, *deductible amounts*, and *out-of-pocket limits*. Providers may bill you directly or request payment of *coinsurance* and/or *copayments* at the time services are provided. Refer to the applicable **Schedules of Benefits** for the specific cost sharing amounts that apply to this *Plan*.

Courtesy Review

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

Covered Charges

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

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

Custodial Care

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

Deductible

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

Dentist

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

Developmental Delay

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

Diagnosis-Related Grouping (DRG)

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

Diagnostic Service

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

Dietary and Nutritional Services

The education, counseling, or training of a *participant* (including printed material) regarding:

1. diet
2. regulation or management of diet
3. the assessment or management of nutrition

Disease

Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the *Plan* is furnished showing that the individual concerned is covered as an *employee* under any workers' compensation law, occupational disease law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one (1) not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the *Plan,* be regarded as a *sickness*, *illness,* or disease.

Durable Medical Equipment (DME)

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

Emergency

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

Emergency Medical Condition

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

Emergency Services

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

Employee

A person who is active on the regular payroll of the *employer*, has begun to perform the duties of their job with the *employer*, and is regularly scheduled to work for the *employer* on a full or part-time basis in an employee/*employer* relationship.

Employer

Means the *Company* and any Participating Affiliates participating in the *Plan*

Essential Health Benefits

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

Experimental/Investigational

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

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

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished
2. if the drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval
3. if reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going Phase I or Phase II clinical trials, is the research, experimental study, or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis
4. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis

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

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

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

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

Explanation of Benefits (EOB)

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

Family Unit

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

Fiduciary

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

Final Internal Adverse Benefit Determination

An *adverse benefit determination* that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an *adverse benefit determination* with respect to which the internal claims and appeals process has been deemed exhausted.

Final Post-Service Appeal

A post-service appeal, which constitutes the last internal appeal available to the *claimant*, to be filed with the *plan administrator*, plan sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals. The term "final post-service appeal" shall only refer to such appeals if medical services and/or supplies have already been provided. Upon filing, adjudication and conclusion of this appeal, external review becomes available to the *claimant*; otherwise in accordance with applicable terms found within the plan document and applicable law. The *plan administrator*, plan sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, reserves the right to allocate certain discretionary authority as it applies to adjudication of final post-service appeals to the *plan appointed claim evaluator* (*PACE*).

Formulary

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

Gene Therapy

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

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

Generic Drug

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

Habilitative Services/Habilitation Services

Treatment and services that help a *plan participant* keep, learn, or improve skills and functions for daily living that they may not be developing as expected for their age range. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

Health Savings Account (HSA)

A tax-exempt or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you *incur*. You must be eligible to qualify for an HSA (refer to the **Schedule of Benefits** section of this document). Both *employer* and *employee* may contribute to an HSA in the same year. Annual contribution limits are subject to IRS guidelines. Participation in a qualified *high deductible health plan* is required for participation in an HSA program.

Home Health Care Agency

An organization that meets all of these tests: its main function is to provide *home health care services and supplies*; it is federally certified as a home health care agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan

Must meet these tests: it must be a formal written plan made by the patient's attending *physician* which is reviewed at least every thirty (30) days; it must state the diagnosis; it must certify that the home health care is in place of *hospital* confinement; and it must specify the type and extent of *home health care services and supplies* required for the treatment of the patient.

Home Health Care Services and Supplies

Include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a *home health care agency* (this does not include general housekeeping services); physical, occupational, and speech therapy; medical supplies; and laboratory services by or on behalf of the *hospital*.

Home Infusion Therapy

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

1. drugs and IV solutions
2. pharmacy compounding and dispensing services
3. all equipment and ancillary supplies necessitated by the defined therapy
4. delivery services
5. patient and family education
6. nursing services

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

Hospice Care Agency

An organization whose main function is to provide *hospice care services and supplies* and is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan

A plan of terminal patient care that is established and conducted by a *hospice care agency* and supervised by a *physician*.

Hospice Care Services and Supplies

Provided through a *hospice care agency* and under a *hospice care plan* and includes *inpatient* care in a *hospice unit* or other licensed facility, home health care, and family counseling during the bereavement period.

Hospice Unit

A facility or separate *hospital* unit that provides treatment under a *hospice care plan* and admits at least two (2) unrelated persons who are expected to die within six (6) months.

Hospital (Acute or Long-Term Acute Care Facility)

A provider licensed and operated as required by law, which provides all of the following and is fully accredited by The Joint Commission:

1. room, board, and nursing care
2. a staff with one (1) or more doctors on hand at all times
3. twenty-four (24) hour nursing service
4. all the facilities on site are needed to diagnose, care, and treat an *illness* or *injury*

The term hospital does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. custodial care
6. educational care
7. subacute care

Refer to the defined terms for *Residential Treatment Facility* and *Substance Use Disorder/Mental Health Treatment Center* for the specific requirements applicable to those facility types.

Hospital Admission

The period between the time of a *participant's* entry into a *hospital* or a chemical dependency treatment center as a bed patient and the time of discontinuance of bed-patient care or discharge by the admitting *physician*, behavioral health practitioner or *professional other provider*, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a hospital admission. If a *participant* is admitted to and discharged from a *hospital* within a twenty-four (24)-hour period but is confined as a bed patient in a bed accommodation during the period of time he is confined in the *hospital*, the admission shall be considered a hospital admission by the Claim Administrator.

For the purpose of this definition, bed patient means confinement in a bed accommodation of a chemical dependency treatment center on a twenty-four (24)-hour basis or in a bed accommodation located in a portion of a *hospital* which is designed, staffed, and operated to provide acute, short-term *hospital* care on a twenty-four (24)-hour basis; the term does not include confinement in a portion of the *hospital* (other than a chemical dependency treatment center) designed, staffed, and operated to provide long-term institutional care on a residential basis.

Identification Card

The card issued to the *employee* by the *Claim Administrator* of the *Plan* indicating pertinent information applicable to his or her coverage.

Illness

A bodily disorder, *disease*, physical illness, or *mental disorder*. Includes *pregnancy*, childbirth, miscarriage, or complications of *pregnancy*.

Incurred

An expense for a service or supply is incurred on the date the service or supply is furnished. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Infertility

Incapable of producing offspring.

Injury

An accidental bodily injury, which does not arise out of, which is not caused or contributed by, and which is not a consequence of, any employment or occupation for compensation or profit.

Inpatient

Treatment in an approved facility during the period when charges are made for *room and board*.

Institution

A facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a *hospital*, *ambulatory surgical center*, *psychiatric hospital*, community mental health center, residential treatment facility, psychiatric treatment facility, *substance use disorder treatment center*, alternative *birthing center*, home health care center, or any other such facility that the *Plan* approves.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a *hospital* solely for the care and treatment of patients who are critically *ill*. This also includes what is referred to as a coronary care unit or an acute care unit. It has facilities for special nursing care not available in regular rooms and wards of the *hospital*; special lifesaving equipment which is immediately available at all times; at least two (2) beds for the accommodation of the critically *ill*; and at least one (1) registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

In-Network

An arrangement under which services are provided to *plan participants* through a select group of providers.

Investigational

See *Experimental/Investigational*.

Life-Threatening Disease or Condition

Any *disease* or condition from which the likelihood of death is probable unless the course of the *disease* is interrupted.

Long Term Acute Care Hospitals

Facilities that specialize in the treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures.

Long Term Care

Generally refers to non-medical care for patients who need assistance with basic daily activities such as dressing, bathing, and using the bathroom. Long-term care may be provided at home or in facilities that include nursing homes and assisted living.

Maintenance Care

Therapy or treatment intended primarily to maintain general physical conditions, including, but not limited to routine, long-term, or maintenance care which is provided after the resolution of an acute medical problem. This includes services performed solely to preserve the present level of function or prevent regression for an *illness*, *injury*, or condition that is resolved or stable.

Marriage and Family Therapy

The provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems

Mastectomy

The surgical removal of all or part of a breast.

Maximum Amount or Maximum Allowable Charge

The benefit payable for a specific coverage item or benefit under the *Plan*. Maximum allowable charge(s) will be based on one (1) of the following options, depending on the circumstances of the *claim* and at the discretion of the *Plan Administrator*:

1. *network* allowed amount
2. the *usual and customary* and/or *reasonable* amount
3. the *allowable charge* specified under the terms of the *Plan*
4. the negotiated rate established in a contractual arrangement with a provider
5. the actual billed charges for the covered services
   The *Plan* will consider the actual charge billed if it is less than the *usual and customary* and/or *reasonable* amount. The *Plan* has the discretionary authority to decide if a charge is *usual and customary* and/or *reasonable* for a *medically necessary* service.

6. *Out-of-network claims* cannot exceed 140% of Medicare. If there is not a Medicare-like rate available, the *out-of-network claim* will be priced at 80% of the *usual and customary* and/or *reasonable* amount.

The maximum allowable charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Maximum Benefit

Any one (1) of the following, or any combination of the following:

1. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* during the entire time he or she is covered by this *Plan*
2. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* for a particular *covered charge*

   The *maximum amount* can be for either of the following:

   a. the entire time the *plan participant* is covered under this *Plan*
   b. a specified period of time, such as a *calendar year*
3. the maximum number as outlined in the *Plan* as a *covered charge*

   The maximum number relates to the number of:

   a. treatments during a specified period of time
   b. days of confinement
   c. visits by a *home health care agency*

Medical Care Facility

A *hospital*, a facility that treats one (1) or more specific ailments, or any type of *skilled nursing facility*.

Medical Management Administrator

A team of medical care professionals selected to conduct *pre-certification* review, *emergency* admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the **Health Care Management Program** section of this document.

Medical Non-Emergency Care

Care which can safely and adequately be provided other than in a *hospital*.

Medically Necessary/Medical Necessity

Care and treatment which is recommended or approved by a *physician* or *dentist*; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a *physician* recommends or approves certain care does not mean that it is medically necessary.

The *Plan Administrator* has the discretionary authority to decide whether care or treatment is medically necessary.

Medicare

The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder and Nervous Disorders/Substance Use Disorder

Any *disease* or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Mental Health or Substance Use Disorder Hold

An involuntary detainment, by an officer of the court, in an *in-patient facility*, of an individual who is either posing a danger to themselves or others or determined to be gravely disabled due to a mental health condition. Typically lasting up to seventy-two (72) hours.

1.

Morbid Obesity

Severity of obesity judged appropriate for procedure, as indicated by one (1) or more of the following:

1. adult patient has BMI of thirty-five (35) or greater
2. adolescent patient [thirteen (13) to seventeen (17) years of age] has a BMI of forty (40) (or 140% of the 95th percentile in age and sex matched growth chart) or greater
3. adult patient has BMI of thirty (30) or greater and a clinically serious condition related to obesity (e.g. type 2 diabetes, obesity hypoventilation, obstructive sleep apnea, non-alcoholic steatohepatitis, pseudotumor cerebri, severe osteoarthritis, difficult to control hypertension)
4. adolescent patient [thirteen (13) to seventeen (17) years of age] has a BMI of thirty-five (35) (or 120% of the 95th percentile in age and sex matched growth chart) or greater and a clinically serious condition related to obesity (e.g. type 2 diabetes, obstructive sleep apnea, non-alcoholic steatohepatitis, pseudotumor cerebri, Blount disease, slipped capital femoral epiphysis
5. adult patient has BMI of thirty (30) or greater with type 2 diabetes mellitus with inadequately controlled hyperglycemia despite optimal medical treatment (e.g. oral medication, insulin)
6. as outlined in the *Medical Management Administrator's medical necessity* criteria in use at the time of a morbid obesity *surgical procedure*

Network

See *In-Network*.

Non-Network

See *Out-of-Network*.

Open Enrollment Period

The annual period during which you and your *dependents* are eligible to enroll for coverage or change benefit plan options.

Other Provider

A person or entity, other than a *hospital* or *physician*, that is licensed where required to furnish to a *participant* an item of service or supply described herein as *covered charges*. Other provider shall include:

1. **Facility Other Provider.** An institution or entity, only as listed:
    a. Chemical Dependency Treatment Center
    b. Crisis Stabilization Unit or Facility
    c. Durable Medical Equipment Provider
    d. Home Health Agency
    e. Home Infusion Therapy Provider
    f. Hospice
    g. Imaging Center
    h. Independent Laboratory
    i. Prosthetics/Orthotics Provider
    j. Psychiatric Day Treatment Facility
    k. Renal Dialysis Center

l. Residential Treatment Center for Children and Adolescents

m. Skilled Nursing Facility

n. Therapeutic Center

2. **Professional Other Provider.** A person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:

a. Advanced Practice Nurse

b. Doctor in Psychology

c. Doctor of Chiropractic

d. Doctor of Dentistry

e. Doctor of Optometry

f. Doctor of Podiatry

g. Licensed Acupuncturist

h. Licensed Audiologist

i. Licensed Chemical Dependency Counselor

j. Licensed Clinical Social Worker

k. Licensed Dietitian

l. Licensed Hearing Instrument Fitter and Dispenser

m. Licensed Marriage and Family Therapist

n. Licensed Occupational Therapist

o. Licensed Physical Therapist

p. Licensed Professional Counselor

q. Licensed Speech-Language Pathologist

r. Licensed Surgical Assistant

s. Nurse First Assistant

t. Physician Assistant

u. Psychological Associates who work under the supervision of a Doctor in Psychology

In states where there is a licensure requirement, other providers must be licensed by the appropriate state administrative agency.

Out-of-Network

Services rendered by a non-participating provider within the designated *in-network* area.

Out-of-Pocket Limit

A *Plan's* limit on the amount a *plan participant* must pay out of their own pocket for medical expenses *incurred* during a *calendar year*. Out-of-pocket limits accumulate on an individual, family, or combined basis. After a *plan participant* reaches the out-of-pocket limit, the *Plan* pays benefits at a higher rate.

Outpatient

Treatment including services, supplies, and medicines provided and used at a *hospital* under the direction of a *physician* to a person not admitted as a registered bed patient; or services rendered in a *physician's* office, laboratory, x-ray facility, *ambulatory surgical center*, or the patient's home.

Patient Protection and Affordable Care Act of 2010 (PPACA)

The Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Jointly, these laws are referred to as PPACA.

Pharmacy

A licensed establishment where covered *prescription drugs* are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician

A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his/her license.

Also see *Other Provider*.

Plan

The Energy Transfer LP Health and Welfare Program for Active Employees, which is a benefits plan for certain *employees* of Energy Transfer LP and its affiliates, and is described in this document. The Energy Transfer LP Health and Welfare Program for Active Employees is a distinct entity, separate from the legal entity that is your *employer*.

Plan Administrator

Energy Transfer LP, which is the named fiduciary of the *Plan*, and exercises all discretionary authority and control over the determination of eligibility to participate in the *Plan*

Plan Appointed Claim Evaluator (PACE)

An entity appointed by the *Plan Administrator*, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle *appeals*, with authority to make final, binding (insofar and to the same extent as a decision by the *Plan Administrator*, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle *appeals*, would be deemed to be binding), *claims* processing decisions in response to f*inal post-service appeals*. In instances where the *Plan Administrator*, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle *appeals*, delegates fiduciary authority to the *PACE*, the *PACE* may exercise the same level of discretionary authority as that which the *Plan Administrator*, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle *appeals*, may otherwise exercise. The *PACE's* fiduciary duties extend only to those determinations actually made by the *PACE*. The *PACE* may perform other tasks on behalf of and in consultation with the *Plan Administrator*, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle *appeals*, but the *PACE* shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via *final post-service appeal*. The *PACE* shall at all times strictly abide by and make determination in accordance with the terms of the *Plan* and applicable law, in light of the facts, law, medical records, and all other information submitted to the *PACE*.

Plan Participant/Participant

Any *employee* or *dependent* who is covered under this *Plan*.

Plan Year

The twelve (12) month period beginning on either the effective date of the *Plan* or on the day following the end of the first plan year which is a short plan year.

Pre-Admission Tests/Testing

Those *diagnostic services* done prior to scheduled *surgery*, provided that all of the following conditions are met:

1. The tests are approved by both the *hospital* and the *physician*.
2. The tests are performed on an *outpatient* basis prior to *hospital* admission.
3. The tests are performed at the *hospital* into which confinement is scheduled, or at a qualified facility designated by the *physician* who will perform the *surgery*.

Pre-Certification/Pre-Certified

An evaluation conducted by a utilization review team through the Health Care Management Program to determine the *medical necessity* and *reasonableness* of a *plan participant's* course of treatment.

Pregnancy

Childbirth and conditions associated with pregnancy, including complications.

Prescription Drug

Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed *physician*. Such drug must be *medically necessary* in the treatment of an *illness* or *injury*.

Preventive Care

Certain preventive services mandated under the *Patient Protection and Affordable Care Act of 2010* (*PPACA*) which are available without cost sharing when received from an *in-network* provider. To comply with *PPACA*, and in accordance with the recommendations and guidelines, the *Plan* will provide *in-network* coverage for:

1. evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations
2. recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention
3. comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA)
4. comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA)

Copies of the recommendations and guidelines may be found here: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations**.

Primary Care Physician (PCP)

A family practitioner, obstetrician/gynecologist, pediatrician, behavioral health practitioner, an internist or a physician assistant or advanced practice nurse who works under the supervision of one of these.

Prior to Effective Date or After Termination Date

Dates occurring before a *plan participant* gains eligibility from the *Plan*, or dates occurring after a *plan participant* loses eligibility from the *Plan*, as well as charges *incurred* prior to the effective date of coverage under the *Plan* or after coverage is terminated, unless extension of benefits applies.

Psychiatric Hospital

An *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospitals*, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally *ill* persons either by, or under the supervision of, a *physician*.
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided.
3. It is licensed as a psychiatric hospital.
4. It requires that every patient be under the care of a *physician*.
5. It provides twenty-four (24) hour per day nursing service.

The term psychiatric hospital does not include an *institution*, or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care*, or educational care.

Qualified Individual

An individual who is a covered participant or beneficiary in this *Plan* and who meets the following conditions:

1. the individual is eligible to participate in an *approved clinical trial* according to the trial protocol with respect to the treatment of cancer or other life-threatening *disease* or condition; and
2. either:
    a. The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.
    b. The *participant* or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.

Reasonable

In the *Plan Administrator's* discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of *illness* or *injury* not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the *Plan Administrator*, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards, and practices as they relate to similar scenarios; and the cause of *injury* or *illness* necessitating the services and/or charges.

This determination will consider, but will not be limited to, the findings and assessments of the following entities:

1. The National Medical Associations, societies, and organizations
2. The Food and Drug Administration

To be reasonable, services and/or fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care, and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The *Plan Administrator* retains discretionary authority to determine whether services and/or fees are reasonable based upon information presented to the *Plan Administrator*. A finding of provider negligence and/or malpractice is not required for services and/or fees to be considered not reasonable.

Charges and/or services are not considered to be reasonable, and as such are not eligible for payment (exceed the *maximum allowable charge*), when they result from provider error(s) and/or facility-acquired conditions deemed reasonably preventable through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The *Plan* reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the *Plan* and to identify charges and/or services that are not reasonable, and therefore not eligible for payment by the *Plan*.

Reconstructive

Procedures are considered reconstructive when intended to address a significant variation from normal related to accidental *injury*, *disease*, trauma, treatment of a *disease*, or a congenital defect.

Rehabilitation Hospital

An *institution* which mainly provides therapeutic and restorative services to *ill* or *injured* people. It is recognized as such if it meets the following criteria:

1. It carries out its stated purpose under all relevant federal, state, and local laws.
2. It is accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities.

Residential Treatment Facility

A provider licensed and operated as required by law, which includes:

1. room, board, and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with twenty-four (24) hour availability
2. a staff with one (1) or more doctors available at all times
3. residential treatment takes place in a structured facility-based setting

4. the resources and programming to adequately diagnose, care, and treat a psychiatric and/or substance use disorder
5. facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care
6. is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term residential treatment center/facility does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. custodial care
6. educational care

Room and Board

A *hospital's* charge for:

1. room and linen service
2. dietary service, including meals, special diets, and nourishment
3. general nursing service
4. other conditions of occupancy which are *medically necessary*

Sickness

See *Disease*.

Skilled Nursing Facility

A facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an *inpatient* basis to persons recovering from an *injury* or *illness*. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a *physician*.
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, *custodial care*, or educational care.

This term also applies to charges *incurred* in a facility referring to itself as an extended acute rehabilitation facility, long-term acute care facility, or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care

Skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a *physician* to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Substance Abuse/Substance Use Disorder

The DSM-5 definition is applied as follows: Substance use disorder describes a problematic pattern of using alcohol or another substance (whether obtained legally or illegally) that results in impairment in

daily life or noticeable distress. An individual must display two (2) of the following eleven (11) symptoms within twelve (12) months:

1. consuming more alcohol or other substance than originally planned
2. worrying about stopping or consistently failed efforts to control one's use
3. spending a large amount of time using drugs/alcohol, or doing whatever is needed to obtain them
4. use of the substance results in failure to fulfill major role obligations such as at home, work, or school
5. craving the substance (alcohol or drug)
6. continuing the use of a substance despite health problems caused or worsened by it

   This can be in the domain of mental health (psychological problems may include depressed mood, sleep disturbance, anxiety, or blackouts) or physical health.
7. continuing the use of a substance despite its having negative effects in relationships with others (for example, using even though it leads to fights or despite people's objecting to it)
8. repeated use of the substance in a dangerous situation (for example, when having to operate heavy machinery, when driving a car)
9. giving up or reducing activities in a person's life because of the drug/alcohol use
10. building up a tolerance to the alcohol or drug

    Tolerance is defined by the DSM-5 as either needing to use noticeably larger amounts over time to get the desired effect or noticing less of an effect over time after repeated use of the same amount.
11. experiencing withdrawal symptoms after stopping use

    Withdrawal symptoms typically include, according to the DSM-5: anxiety, irritability, fatigue, nausea/vomiting, hand tremor or seizure in the case of alcohol.

Substance Use Disorder/Mental Health Treatment Center

An *institution* which provides a program for the treatment of *substance use disorder* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be at least one (1) of the following:

1. affiliated with a *hospital* under a contractual agreement with an established system for patient referral
2. accredited as such a facility by the Joint Commission or CARF
3. licensed, certified, or approved as an alcohol or *substance use disorder* treatment program or center by a state agency having legal authority to do so
4. is a facility operating primarily for the treatment of *substance use disorder* and meets these tests:
   a. maintains permanent and full-time facilities for bed care and full-time confinement of at least twenty-four (24) hour-per-day nursing service by a registered nurse (R.N.)
   b. has a full-time psychiatrist or psychologist on the staff
   c. is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of *substance use disorder*

Surgery/Surgical Procedure

Any of the following:

1. the incision, excision, debridement, or cauterization of any organ or part of the body and the suturing of a wound
2. the manipulative reduction of a fracture or dislocation or the manipulation of a joint, including application of cast or traction

3. the removal by endoscopic means of a stone or other foreign object from any part of the body, or the diagnostic examination by endoscopic means of any part of the body
4. the induction of artificial pneumothorax and the injection of sclerosing solutions
5. arthrodesis, paracentesis, arthrocentesis, and all injections into the joints or bursa
6. obstetrical delivery and dilatation and curettage
7. biopsy
8. surgical injection

Temporomandibular Joint (TMJ)

The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves, and other tissues related to the temporomandibular joint.

Urgent Care Facility

A free-standing facility, regardless of its name, at which a *physician* is in attendance at all times that the facility is open, that is engaged primarily in providing minor *emergency* and episodic medical care to a *plan participant*.

Usual and Customary Charge

Covered charges which are identified by taking into consideration the fees which the provider most frequently charges (or accepts) for the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same area by providers of similar training and experience for the service or supply, and the *Medicare* reimbursement rates. The term(s) 'same geographic locale' and/or 'area' shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons, or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be usual and customary, fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term 'usual' refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, *pharmacies*, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was *incurred*.

The term 'customary' refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one (1) individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale.

The term 'usual and customary' does not necessarily mean the actual charge made (or accepted), nor the specific service or supply furnished to a *plan participant* by a provider of services or supplies, such as a *physician*, therapist, nurse, *hospital*, or pharmacist. The *Plan Administrator* will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service, or supply is customary.

Usual and customary charges may alternatively be determined and established by the *Plan* using normative data such as, but not limited to, *Medicare* cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer's retail pricing (MRP) for supplies and devices.

If you have questions about your *Plan* benefits, please contact the *Claim Administrator* at 1-866-215-0976.

P.O. Box 7186
Boise ID 83707