Trustmark
benefits beyond benefits

May 26, 2022

AERIE CORPORATION
804 PENDLETON ST
GREENVILLE, SC 29601

RE: **IMPORTANT INFORMATION REGARDING YOUR HEALTH BENEFITS**

Dear Plan Participant:

The U.S. Department of Labor (DOL) and the IRS have issued a Notification of Relief that temporarily extends certain deadlines under your group health benefit plan, including those related to special enrollee elections, COBRA elections and COBRA premium payments, filing claims and claim appeals. Enclosed is a chart identifying the extension of certain deadlines that affect your benefits under your employer-sponsored, self-funded health benefit plan administered by Star Marketing and Administration, Inc. You may access this chart online at https://bit.ly/time-frame-extension.

If you have any questions or concerns, please call 800.522.1246, ext. 26300.

Enclosures

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Federal Extension of Certain Time Frames Under Group Health Benefit Plans

Due to the coronavirus (COVID-19) pandemic, federal agencies have temporarily extended certain deadlines under group health benefit plans, including dental plans, disability and other plans subject to ERISA and the Internal Revenue Code, including HRAs and FSAs. The U.S. Department of Labor (DOL) and the IRS have issued a notification of relief that affects a number of deadlines, including those related to special enrollee elections, COBRA coverage, and filing claims and appeals.

The COVID-19 outbreak in the United States was declared a national emergency, beginning March 1, 2020. The relief notification extends certain time frames by mandating the period starting March 1 through 60 days after the national emergency is over (known as the "outbreak period") to **not** be considered in applying certain deadlines. The date for the end of the national emergency has not yet been announced.[1] However, the extension cannot exceed one year.

On February 26, 2021, the federal Employee Benefits Security Administration (EBSA) issued EBSA Disaster Relief Notice 2021-01, which requires the extension of certain time frames for individuals and plans be disregarded until the earlier of:

- 1 year from the date they were first eligible for relief; or
- 60 days after the announced end of the National Emergency (the end of the Outbreak Period).

In no case will a disregarded period exceed 1 year.

We will administer plans consistent with these temporarily extended deadlines mandated by the federal government. The chart below identifies the deadlines that affect employer-sponsored, ERISA self-funded health benefit plans administered by Star Marketing and Administration, Inc.

Which Time Frames are Impacted by the Federal Extension?	**What's the Time Frame?**	**Extend the Time Frame for Plans and Individuals by Disregarding the Outbreak Period Until the Earlier of:**
Time Frame for **Special Enrollee** to Elect Coverage[2]	30 days from the qualifying event (i.e. birth, marriage, adoption)	1 year from the date they were first eligible for relief; or 60 days after the announced end of the National Emergency
Time Frame for **Plan to Provide COBRA Election Notice**[3] to Employee/Dependent	14 days from the date the plan administrator is notified of a qualifying event.	1 year from the date they were first eligible for relief; or 60 days after the announced end of the National Emergency

Which Time Frames are Impacted by the Federal Extension?	What's the Time Frame?	Extend the Time Frame for Plans and Individuals by Disregarding the Outbreak Period Until the Earlier of:
Time Frame to **Elect COBRA**[3]	60 days from the later of: a. the date the election notice is furnished; or b. the date coverage ends	1 year from the date they were first eligible for relief; or 60 days after the announced end of the National Emergency
Time frame to **Remit Initial COBRA Premium**[3]	45 days from the COBRA election date	1 year from the date they were first eligible for relief; or 60 days after the announced end of the National Emergency
Time Frame to **Remit Subsequent COBRA Premium**[3]	Within the 30 day grace period after the first day of the coverage period	1 year from the date they were first eligible for relief; or 60 days after the announced end of the National Emergency
Time Frame to **Provide Notice of Qualifying Event**	60 days from qualifying event (i.e. divorce, loss of dependent child status, disability)	1 year from the date they were first eligible for relief; or 60 days after the announced end of the National Emergency
Time Frame to **Submit a Claim**	Deadline to file a claim under the plan (time frame may vary from plan to plan but is often 12 months)	1 year from the date they were first eligible for relief; or 60 days after the announced end of the National Emergency
Time Frame to **Submit a Request for Internal Appeal**	180 days from receipt of notice of adverse benefit determination	1 year from the date they were first eligible for relief; or 60 days after the announced end of the National Emergency
Time Frame to **Submit a Request for External Appeal**[2]	4 months from receipt of final adverse benefit determination	1 year from the date they were first eligible for relief; or 60 days after the announced end of the National Emergency

Which Time Frames are Impacted by the Federal Extension?	What's the Time Frame?	Extend the Time Frame for Plans and Individuals by Disregarding the Outbreak Period Until the Earlier of:
Time Frame to **Perfect a Request for External Appeal**[2]	The later of: a. The end of the 4-month period in which to request an external appeal; or b. 48 hours from receipt of notification that explains the request for external review is incomplete and describes the information or materials needed to make the request complete.	1 year from the date they were first eligible for relief; or 60 days after the announced end of the National Emergency

Review your plan document for plan-specific time frames.

Employees who are impacted by these changes and have questions can call Customer Service at 800.522.1246.

To learn more, visit bit.ly/summary-time-frame-extension.

For more on benefit changes due to COVID-19, visit trustmarkbenefits.com/Small-Business-Benefits/COVID-19.

[1]The date of the end of the national emergency could vary for different parts of the country, if public emergencies end at different times in different states or regions.

[2]Does not apply to limited scope dental or disability income plans.

[3]COBRA is applicable only for members/dependents of groups with more than 20 employees in the prior year. COBRA does not apply to disability income plans.

AERIE CORPORATION GROUP HEALTH BENEFIT PLAN

SM89426E

PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

Administered by Star Marketing and Administration, Inc.

400 Field Drive • Lake Forest, Illinois 60045 • 800.522.1246 • TrustmarkSB.com

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Plan Document

Employer:
AERIE CORPORATION
804 PENDLETON ST
GREENVILLE, SC 29601

Group Number: SM89426E

Participant ID:

Class:

Participant Effective Date:

The effective date of this Plan Document is: August 1, 2022

Claim Processor:
Star Marketing and Administration, Inc.
P.O. Box 2942
Clinton, Iowa 52733-2942

ADOPTION

AERIE CORPORATION has caused this AERIE CORPORATION Health Benefit Plan (***Plan***) to take effect as of August 1, 2022. I have read the document herein and certify the document reflects the terms and conditions of the employee welfare benefit plan as established by AERIE CORPORATION .

BY:_____ DATE:_____

Summary Plan Description

Name of Plan: AERIE CORPORATION Health Benefit Plan

Plan Sponsor/Plan Administrator and
Agent for Service of Legal Process:
AERIE CORPORATION
804 PENDLETON ST
GREENVILLE, SC 29601

Group Number: SM89426E

Participant ID:

Participant Effective Date:

Phone Number: 864-527-5500

Employer Identification Number: 571072446

The Effective Date of this Plan Document is: August 1, 2022
The Ending Date of Plan Year: June 30, 2023

Type of Plan: Group Health Plan

Type of Benefits: Major Medical benefits including Prescription Drug as described in the Plan Document.

Type of Administration: Contract administration. The processing of claims for benefits under the terms of the Plan is provided through one or more companies contracted by the Employer and shall hereinafter be referred to as the Claim Processor.

Eligibility Requirements for This Plan: For detailed information regarding a person's eligibility to participate in the Plan, refer to the Eligibility and Effective Date of Coverage section in the Plan Document.

For detailed information regarding a Participant being ineligible for benefits through reaching maximum benefit levels, termination of coverage or Plan exclusions, refer to the following sections:

- Schedule of Benefits
- Termination of Coverage
- Exclusions and Limitations

Preferred Provider Networks: The Plan requires the use of certain pharmacies for Specialty Drug benefits and the use of a Designated Transplant Facility for transplant benefits. The Plan also contains pre-certification requirements. Refer to the Plan Document for detailed information concerning pre-certification, Specialty Drugs and transplant benefits.

Prescription Drugs, Preventive Services, Tests, Procedures and Medical Equipment: Such services are covered as specified in the Plan Document.

Emergency Services: Refer to the Plan Document for detailed information concerning Emergency Services coverage. Pre-certification is not required for Emergency Services but is required for certain other non-Emergency Services. Refer to the Plan Document for detailed information.

Maternity and Newborn Coverage: The Plan may provide maternity and newborn coverage. The Plan Document will describe benefits for Hospital stays in connection with childbirth for the mother and the newborn.

Procedures to be followed in Presenting Claims and Remedies Available if a Claim is Rejected: Refer to the Claim Review and Appeal Rights under Federal Law Notice in Your Plan Document.

Continuation of Coverage/Extension of Benefits other than COBRA: If COBRA continuation (described below) does not apply to You, You may still be eligible to continue coverage temporarily in certain situations. Refer to the Plan Document for information concerning continuation of coverage rights.

Sources and Methods of Determining Contributions to the Plan: Contributions for Plan expenses are obtained from the Employer and from covered employees. The Employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the Employer and the amount to be contributed by the covered employees.

Funding Method: The Employer pays Plan benefits and administration expenses directly from general assets. Contributions received from Eligible Employees are used to cover Plan costs and are expended immediately.

Cost Sharing Provisions: The Plan Document contains detailed information concerning cost sharing provisions including premium, Deductible, Coinsurance, co-payments, out-of-pocket expenses, and lifetime and annual benefit maximums.

Procedures for Filing Claims: For detailed information on the procedures governing claims for benefits, or how to file an appeal, refer to the Precertification Requirement section and Claim Review and Appeal Rights section in the Plan Document.

Medical claims should be sent to the address listed on Your identification card.

Prescription Drug claims must be sent to:
CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Consumer Assistance Information: Participants may seek consumer assistance information by contacting: 800-522-1246 or TrustmarkSB.com/login.

Qualified Medical Child Support Order: A copy of Qualified Medical Child Support Order procedures may be obtained by submitting a written request to the Plan Administrator.

Standards Relating to Benefits for Mothers and Newborns: If the Schedule of Benefits shows that You have coverage for Pregnancy and Routine Nursery Care, this Plan generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, this Plan may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of ERISA Rights:

The Plan Sponsor may terminate the Plan or amend or eliminate benefits at any time. However, as a Participant in this benefit Plan You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

A. Receive Information about Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan Documents, including insurance contracts, and a copy of the latest annual report (form 5500 Series if applicable) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

2. Obtain, upon written request, copies of all documents governing the operation of this Plan, including insurance contracts, copies of the latest annual report (Form 5500 Series if applicable) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

B. COBRA - Continue Group Health Coverage

If the Plan Sponsor is required to provide continuation coverage under the Consolidated Budget Reconciliation Act (COBRA), You may continue health care coverage for Yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights. The Plan Sponsor/Plan Administrator is responsible for informing employees of their COBRA rights and obligations and providing COBRA election notices.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate this Plan, called “fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan Participants and beneficiaries. No one, including Your Employer, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Named Fiduciary for Health Benefit Plan Claims: Claim Processor is a named fiduciary for purposes of making decisions of whether a claim for benefits is payable under the terms of this Plan.

Enforce Your Rights

If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file a suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance with Your Questions

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

Schedule of Benefits
Comprehensive Medical Coverage

Coverage for this benefit is

Deductible

$0 per person per Plan Year
$0 per family per Plan Year

A Participant with individual coverage must satisfy the per person Deductible before Coinsurance applies to that person. For those with family coverage, each Participant must satisfy the per person Deductible, unless the per family Deductible is already met. The amounts applied to the per person Deductible accumulate toward the per family Deductible and will not exceed the per family Deductible.

Access Fees and Precertification Penalty

$1,500 per Outpatient Surgery (waived if performed in an Emergency Room)
$1,500 per Inpatient Admission
$300 penalty if the procedures under the Precertification Requirement section of this Plan Document are not followed.

Note: There are no annual limits on the Precertification Requirement penalties and they will not count towards Your individual or family Deductibles or Out-of-Pocket Limits.

	Coinsurance and Copays (all payments are a percentage of Covered Charges)**	Out-of-Pocket Limit (includes Deductible, Coinsurance, Copay and access fees as applicable)
Covered Charges other than those listed below (after Deductible)	50%	Individual $5,000 Family $10,000
Outpatient Mental Illness or Nervous Disorders, substance abuse and alcohol abuse. Includes Telemedicine Services provided by non-Teladoc providers (after Deductible).	50%	
Inpatient Mental Illness or Nervous Disorders, substance abuse and alcohol abuse (after Deductible)	50%	
Physician/Specialist Office Visit and Manipulative Therapy. Includes Telemedicine Services provided by non-Teladoc providers.	$40 Copay, then 100%	
Telemedicine Services provided by Teladoc, including general medical, dermatology, Mental Illness or Nervous Disorders, substance abuse and alcohol abuse.	$0 Copay	
Urgent Care Center Visit	$40 Copay, then 100%	

Emergency Services	$500 Copay, then 100%
Speech, Physical, Occupational Therapy (This is in addition to the Physician Office Visit Copay)	$40 Copay, then 100%
Outpatient Advanced Imaging	$300 Copay per procedure, then 100%

**Subject to Reasonable Fee limitations. Please refer to the Definitions section of this Plan Document for more information on Reasonable Fees.

Schedule of Benefits
Comprehensive Medical Coverage

Benefits Included

Pregnancy and Routine Nursery Care Benefit

Prescription Drug Card Benefit:

100% of charges for contraceptives, oral or other, whether medication or device.

$0 Annual Prescription Deductible per person for Preferred (Tier 2) and Nonpreferred Drugs (Tier 3)

Copay per prescription:

Retail - up to a 30-day supply

$20 for Generic Prescription Drugs (Tier 1)
$65 for Preferred Brand Name Drugs (Tier 2)
$95 for Nonpreferred Brand Name Drugs (Tier 3)
$200 for Specialty Drugs (Tier 4)

Mail Order - up to a 90-day supply

$40 for Generic Prescription Drugs (Tier 1)
$160 for Preferred Brand Name Drugs (Tier 2)
$285 for Nonpreferred Brand Name Drugs (Tier 3)

Note: The annual Prescription Deductible, Coinsurance and Copays will apply toward the Out-of-Pocket Limit described on this Schedule of Benefits. Manufacturer coupons or copay cards will not be applied toward the satisfaction of a Participant's Deductible or Out-of-Pocket Limit.

Specialty Drugs not approved by or obtained through the Designated Specialty Pharmacy are not covered.

Outpatient Diagnostic X-ray and Lab: 100%
(this benefit does not apply to Outpatient advanced imaging, including but not limited to CT, MRI, and PET scans)

Preventive Care Services: 100% of preventive care procedures.

Women's Preventive Services: 100% of preventive care procedures.

Schedule of Benefits
Comprehensive Medical Coverage

Benefit maximums (per Participant)

Lifetime Dollar Maximum Amount	Unlimited for Essential Health Benefits.
Inpatient Covered Charges relating to Mental Illness or Nervous Disorders, substance abuse and alcohol abuse	20 days per Plan Year; 40 days while covered under this Plan.
Outpatient Covered Charges relating to Mental Illness or Nervous Disorders, substance abuse and alcohol abuse	40 visits per Plan Year; 120 visits while covered under this Plan.
Speech therapy	60 visits per Plan Year.
Physical therapy	60 visits per Plan Year.
Occupational therapy	60 visits per Plan Year.
Manipulative therapy	20 visits per Plan Year.
Chronic Pain treatment programs	10 visits per Plan Year.
Hospice care	6 months while covered under this Plan.
Skilled nursing care	81 days per Plan Year.
Home health care	100 days per Plan Year.
Acupuncture	12 visits per Plan Year.
Massage Therapy	12 visits per Plan Year.
Naturopathic Medicine	12 visits per Plan Year.
Nutritional Counseling	3 visits while covered under this Plan, except to the extent such services are eligible under the Preventive Care Services benefit.
Hair prosthesis for alopecia resulting from cancer treatment that involves chemotherapy or radiation therapy	100% coverage for one hair prosthesis per Plan Year.

Schedule of Benefits
Comprehensive Medical Coverage
Transplant Benefit

	Coinsurance	
	Designated Transplant Facility	Non-Designated Transplant Facility
Approved Transplant Services	100%	Not covered
Transportation, Lodging and Meals of Companion	100%	Not covered

Benefit maximums (per Participant)

Transportation of companion ..... $1,000 per Approved Transplant

Lodging and meals of companion ..... $250 per day while recipient of an Approved Transplant is Hospital confined
$10,000 while covered under this Plan

Approved Transplant Services are those defined in the attached Plan Document. See the first page of this Schedule of Benefits for maximum Out-of-Pocket Limits.

Schedule of Benefits
Comprehensive Medical Coverage

ONLINE TRANSPARENCY TOOL

This Plan includes access to a web-based service that enables Participants to research medical providers and facilities that offer a "Fair Price" as described below. Services include the following:

Fair Price information. This tool includes an analysis which sets forth what Participants should expect to pay for specific procedures in a given geographic area. The core approach is high volume, high-price-variability procedures, such as colonoscopies, MRIs or knee arthroscopies. For such procedures, this tool provides information on price ranges, the Fair Price and a list of providers ranked by their price level, allowing Participants to identify high-value providers:

- Green means at or below the Fair Price,
- Yellow means for a slightly higher price,
- Red means for a moderately to significantly higher price.

Provider and Facility Information. Facility and related physician information, including practice details and quality ratings (or similar) are provided to help Participants learn more about the providers listed for certain procedures.

Refer to Your medical benefit identification card for contact information about how to access these services.

SECOND OPINION SERVICES

This Plan includes access to second opinion services to check a medical diagnosis, confirm a course of treatment or learn about a current complex medical condition. Services include the following:

- Access to medical specialists;
- Collection of medical records on behalf of Participant;
- Second opinion regarding a diagnosis or a course of treatment.

Refer to Your medical benefit identification card for contact information about how to access these services.

MATERNITY WELLNESS SERVICES

This Plan includes access to a voluntary program designed to provide prenatal and postnatal education and support to expectant women, and to identify and manage those with risks as early as possible, through continuous monitoring and engagement. This program utilizes proactive outreach from a dedicated maternity nurse specialist and provides access to a 24/7 maternity nurse line. Expectant women who choose to participate in the program will receive telephonic education on strategies for a healthy lifestyle and reducing the risk of a complicated pregnancy.

Refer to Your medical benefit identification card for contact information about how to access these services.

Incentives, Rebates and Contribution

This Plan may elect to furnish or provide Participants with access to programs in addition to those listed above in this Schedule of Benefits. In addition, this Plan may elect to participate in programs provided by other organizations that furnish discounts on services or where other items of value may be offered. The cost for such programs may be discounted, credited, waived or otherwise adjusted. Such discounts, credits, waivers, adjustments or other items of value will not be conditioned on a health-status related factor. Neither We, nor the Claim Processor are liable for the negligent provision of any goods, services or discounts provided through a vendor.

COMPREHENSIVE MEDICAL BENEFITS
Plan Year Deductible

Benefits will be provided for medical expense incurred for the Medically Necessary care and treatment of Sickness or Injury. The amounts of coverage are shown in the Schedule of Benefits.

A. DEFINITIONS

NOTE: All masculine pronouns used in this Plan Document also include the feminine.

Acupuncture: The procedure of inserting and manipulating fine filiform needles into specific points on the body for relief or for therapeutic purposes.

Affordable Care Act: The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 and all applicable regulations and regulatory guidance.

Air Mileage Rate: A Contracted Rate expressed in dollars per loaded mile (statute miles not nautical miles) flown.

Anesthesia Conversion Factor: A Median Contracted Rate expressed in dollars per unit.

Annual Open Enrollment Period: The period of time during which Eligible Employees may enroll themselves and their Eligible Dependents for coverage. The Annual Open Enrollment Period is the month prior to the renewal date of this Plan.

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 in accordance with federal law.

Balance Bill Amount: The amount billed for Covered Conditions by a provider to a Participant or disputed by a Provider to the Claim Processor, in excess of the Reasonable Fee.

Base Unit: For an anesthesia service code, Base Units are specified in the most recent edition (as of the date of service) of the American Society of Anesthesiologists Relative Value Guide.

Certified IDR Entity: An entity responsible for conducting payment determinations through the federal independent dispute resolution process that has been certified by the Secretaries of Labor, Health and Human Services and the Treasury.

Chronic Pain: Persistent and recurring pain that lasts longer than 6 months from the date the pain is first evaluated by a Physician.

Coinsurance: The arrangement by which the cost of Covered Charges is shared by the Participant and Us on a percentage basis. The percentage paid by Us is shown in the Schedule of Benefits.

Complications of Pregnancy: Means conditions which are not part of a normal pregnancy, but are caused by, or made worse by, pregnancy. They include, but are not limited to: (1) Caesarean section, ectopic pregnancy or similar surgery; (2) spontaneous termination of pregnancy during a time a viable birth is not possible; (3) eclampsia, puerperal infection, missed abortion, RH factor problems, severe loss of blood requiring transfusions; (4) acute nephritis, nephrosis, cardiac failure; (5) hyperemesis gravidarum; and (6) other similarly severe conditions related to Pregnancy. Complications of Pregnancy does not include: (1) false labor; (2) occasional spotting; (3) Physician prescribed rest during pregnancy; (4) morning Sickness; (5) pre-eclampsia; or (6) similar conditions which are part of a difficult pregnancy, but which are not a separate complication of pregnancy.

Compound Medications: A randomly prepared dosage form. It must contain at least one Federal Legend Drug or State Restricted Drug within the compound.

Contracted Rate: The total amount (including Cost Sharing) that plan sponsors of self-funded plans administered by Claim Processor are contractually agreed to pay a Preferred Provider for Covered Charges.

Copay: The amount of each covered visit charge that the Participant must pay. This amount does not apply toward satisfaction of any Deductible. This amount does apply toward the satisfaction of the Out-of-Pocket maximum. The Copay is shown in the Schedule of Benefits.

Cost Sharing: The amount a Participant is responsible for paying for Covered Charges. Cost Sharing includes Copays, Coinsurance and Deductible. Cost Sharing does not include balance billing by Nonpreferred Providers for Emergency Services or air ambulance services described in subsections a. or b. of the Nonpreferred

Provider section of this Plan, or the cost of items or services that are not Covered Charges.

Covered Charges: That part of expense incurred which: (a) is for care of a Covered Condition; (b) is incurred while a Participant's coverage is in force; (c) does not exceed the Reasonable Fee; and (d) is listed as a Covered Charge in Part B. of this section, Comprehensive Medical Benefits. Covered Charges are considered incurred on the date a service is rendered or a supply is furnished.

Covered Condition: All Sickness and Injury for which a Participant is covered by this Benefit.

Custodial Care: Room and board and other institutional or nursing services which are provided for a Participant due to his age or mental or physical condition mainly to aid in daily living.

Deductible: The amount of Covered Charges that must be incurred by a Participant before Coinsurance applies. The Deductible will be satisfied when Covered Charges: (1) are incurred for Covered Conditions; and (2) are equal to the Deductible shown in the Schedule of Benefits.

Dependent On Other Care Provider(s): The individual requires a community integrated living arrangement, group home, supervised apartment, or other residential services licensed or certified by the department of mental health and developmental disabilities, the department of public health, the department of public aid, or other appropriate state department responsible for such services or facilities.

Disability/Disabled: You are Disabled if, due to Sickness or Injury, You are unable to do the substantial and material duties of Your regular job. A Dependent is Disabled if, due to Sickness or Injury, he is unable to do his normal activities.

Domestic Partner: A person who is of the same or opposite sex of the Eligible Employee who have chosen to share their lives in close personal relationship in lieu of marriage with the Eligible Employee, and who:

- share the same or regular and permanent residence, and have been living together as a couple in the same household for at least twelve (12) months;
- have an exclusive mutual commitment in lieu of a lawful marriage;
- have agreed to be jointly responsible for basic living expenses incurred during the domestic partnership;
- are not married to anyone;
- are each eighteen (18) years of age or older;
- are not related by blood as close as would bar marriage;
- are mentally competent to consent to a contract when the domestic partnership began;
- are committed to the physical, emotional and financial care and support of each other and share with each other the common necessities and tasks of one household and are financially interdependent;
- are not involved in any other domestic partnership nor signed an affidavit of domestic partnership or its equivalent with a different Domestic Partner in any jurisdiction within twelve (12) months immediately prior to the effective date of coverage.

Eligible Dependent (Dependent): Includes (1) Your legal spouse, as defined by the state or country in which the Eligible Employee was legally married, or Domestic Partner, (2) Your child under 26 years of age, or (3) Your child who has coverage in force, who has reached the limiting age for children but who, because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment and is dependent upon his or her parents or Dependent On Other Care Provider(s) for lifetime care and supervision. You must give proof of the child's incapacity and dependency within 31 days of receipt of a request for such proof. You may also be required, from time to time, to give proof of his continuing incapacity and dependency. If proof is not given within 31 days of a request, his coverage will end 31 days after the request is made. If no inquiry is received, coverage will continue through the term of this Plan or any extension or renewal.

NOTE: 'Child' as used above includes adopted children, stepchildren and foster children. A foster child means a child who is placed with the Eligible Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. But, Eligible Dependent will not include: a child or spouse who lives outside of the USA; or a spouse who is an Eligible Employee.

Eligible Employee: A person who is working for Employer for the minimum number of hours specified by the Employer but not less than 25 hours per week (“minimum number of hours”) or if applicable under the Affordable Care Act, an employee of the Employer who is not currently working the minimum number of hours, but was working on average the minimum number of hours during the Employer's Measurement Period and is eligible during the Employer's Stability Period, as documented by the Employer and consistent with the Affordable Care Act, applicable regulations and regulatory guidance; has satisfied the waiting period, if any, required by the Employer; and is a member of a class eligible for coverage. An Eligible Employee must also be a U.S. Citizen and possess a Social Security number, or a legal alien and possess a green card or valid work visa and Social Security number. A person may be considered an Eligible Employee if they are not actively at work due to Hospital confinement or Disability. An Eligible Employee will not include a person who lives outside of the U.S.

Emergency Admission: An admission to a Hospital as an Inpatient: (a) for a Sickness or Injury which, unless immediately treated on an Inpatient basis, would jeopardize the Participant's life or cause serious health impairment; or (b) for childbirth.

Emergency Medical Condition: A medical condition, including a Mental Illness or Nervous Disorder or substance abuse or alcohol abuse disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, a serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at a Hospital or an Independent Freestanding Emergency Department, as are required to Stabilize the patient.

Employer: The Employer is named on the first page of this Plan Document. The Employer is the Plan Sponsor/Plan Administrator.

Enrollment Period: The 31 day period following the end of the waiting period or, if no waiting period, then the 31 day period following Your hire date where the Eligible Employee and/or his Eligible Dependents must apply for coverage. For Special Enrollees, the 31 day period beginning on the date a qualifying event occurred where the Eligible Employee and/or his Eligible Dependents must apply for coverage.

Essential Health Benefits: Benefits for Medically Necessary care and treatment of Sickness or injury. Essential Health Benefits do not include: Transportation, Lodging or Meals for a Companion under the Transplant Benefit.

Experimental/Investigational: A drug, device or medical treatment or procedure is "experimental" or "investigational":

1. if the drug or device cannot lawfully be 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; or
2. if Reliable Evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials, except for routine patient cost of Approved Clinical Trials as set forth under section B. Covered Charges, or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
3. if Reliable Evidence shows that the consensus of opinion among experts regarding the drug, device or 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 the standard means of treatment or diagnosis.

"Reliable Evidence" means only published reports and articles in authoritative Medical and scientific literature; the written protocol or protocols used by the treating Facility or the protocols of another Facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating Facility or by another Facility studying substantially the same drug, device or medical treatment or procedure.

Facility: A health care institution which meets all applicable state or local licensure requirements. Facility includes, but is not limited to, a Hospital, emergency room, Rehabilitation Facility, skilled nursing center, Free Standing Surgical Center, Urgent Care Center, laboratories, x-ray, MRI or other CT Facilities, and any other health care Facility.

Family Member: You, Your spouse, or the parent, child, brother or sister of You or Your spouse.

Federal Legend Drug: Any drug which must bear the following legend: "Caution: Federal Law prohibits dispensing without a prescription."

Free Standing Surgical Center: A Facility licensed as a free standing or ambulatory surgical center with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous Physician services and registered professional nursing services whenever a patient is in the Facility, and which does not provide service or other accommodations for patients to stay overnight.

Genetic Therapy: Genomic medical treatment and/or genetic therapies that are both commercially available as well of those in development, including, but not limited to Kymriah, Yescarta, Luxturna, gene transfer, delivery of nucleic acid into a patient's cells, treatment of genetic disorders, and any other autologous T-cell immunotherapies, any form of cell therapies, gene therapies, gene regulation or genomic editing.

Habilitative Services: Medically Necessary health care services that help a Participant keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. 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. Habilitative Services that are not Medically Necessary, for example when therapy has reached an end point and goals have been reached, will not be covered.

Habilitative and Rehabilitative Devices: Medically Necessary devices that are designed to assist individuals in acquiring, improving, or maintaining, partially or fully, skills and functioning for daily living. Such devices include, but are not limited to, durable medical equipment (DME), orthotics, prosthetics, and low vision aids.

Hospital: Includes all of the following.
1. An institution which: (a) is operated lawfully; and (b) mainly and continuously provides medical, diagnostic, and surgical facilities; these facilities may be on the premises or available on a prearranged basis supervised by a staff of one or more licensed Physicians; and (c) provides Inpatient care for which a charge is made; and (d) provides 24-hour nursing care by, or supervised by, a registered graduate nurse (R.N.); or
2. An institution which is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations; or
3. Any other institution required to be recognized as a Hospital for benefit payment purposes under the law of the state in which You live.

Hospital does not include a nursing home or a Custodial Care facility.

Imported Drugs: Prescription Drugs imported from outside the United States.

Independent Freestanding Emergency Department: A health care Facility that is geographically separate and distinct and licensed separately from a Hospital under applicable State law and provides Emergency Services.

Injury: Accidental bodily Injury or injuries which cause a covered loss while a Participant's coverage is in force. The Injury must be the direct cause of the loss, independent of disease, bodily infirmity or other cause.

Inpatient: Admission to a Hospital or Rehabilitation Facility with a Physician's order, as an overnight bed patient with a charge for room and board for a Covered Condition. Excludes any period of observation in an observation unit or recovery room, or any period of confinement in a hospice or Custodial Care facility.

Inpatient Admission Access Fee: The amount, in addition to the Plan Deductible, of Covered Charges that must be incurred by a Participant for an Inpatient admission before benefits will be paid. The Inpatient Admission Access Fee will be met when Covered Charges: (1) are incurred for Inpatient Covered Conditions; and (2) are equal to the Inpatient Admission Access Fee shown in the Schedule of Benefits.

Lifetime Maximum Amount: The maximum dollar amount of benefits We will pay on behalf of any Participant over the lifetime of that person showing in the Schedule of Benefits.

Massage Therapy: The manipulation of the soft tissues of the body for the purposes of normalizing those tissues by a trained professional.

Measurement Period: The period of time, as determined by the Employer and consistent with Federal law, regulation and guidance, utilized by the Employer to determine whether a Variable Hour Employee is an Eligible Employee.

Median Contracted Rate: The rate calculated by arranging in order from least to greatest all of the Contracted Rates in a geographic area for the same or similar item or service that is provided by a provider or Facility in the same or similar specialty or Facility type, and selecting the middle number. If there are an even number of Contracted Rates, the Median Contracted Rate is the average of the middle two Contracted Rates. Median Contracted Rates are:
1. calculated separately for CPT code modifiers 26 (professional component) and TC (technical component);
2. based on an Anesthesia Conversion Factor for each anesthesia service code;
3. based on air mileage service codes (A0435 and A0436) for air ambulance services; and
4. calculated separately for each service code-modifier, when Contracted Rates vary based on application of a modifier.

Medically Necessary: A service, drug, or supply that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the U.S. at the time the service, drug or supply is provided. When specifically applied to a confinement it further means that the diagnosis or treatment of the Participant's symptoms or condition cannot be safely provided to that person on an Outpatient basis.

A service, drug, or supply shall not be considered as Medically Necessary if it:
1. is Experimental/Investigational, or for research purposes; or
2. is provided solely for the convenience of the patient, the patient's family, Physician, Hospital or any other provider; or
3. exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or
4. could have been omitted without adversely affecting the Participant's condition or the quality of medical care; or
5. involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration; or
6. involves a service, supply or drug not approved for reimbursement by the Centers for Medicare and Medicaid Services or any successor organization; or
7. is a misrepresentation of services provided.

Benefit payment is subject to the determination under this Plan that the service, drug or supply is Medically Necessary. The fact that a Physician may prescribe, authorize, or direct a service, drug or supply to be prescribed, does not of itself make it Medically Necessary or covered under this Plan Document.

Medicare: Title XVIII of the Social Security Act of 1965, as amended. A Participant is considered to be eligible for Medicare on and after the date he is first eligible for any Medicare coverage.

Mental Illness or Nervous Disorders: Means neurosis, psychoneurosis, psychopathy, psychosis and mental disease or disorders as defined in the most current edition of the Diagnostic and Statistical Manual of Disorders of the American Psychiatric Association.

Naturopathic Medicine: Treatment or consultation provided by a medical doctor (MD), doctor of naturopathy (DN), or a trained provider of naturopathy (ND).

Negotiated Amount: The amount paid by the Plan to a provider in excess of the Reasonable Fee for Covered Conditions as a result of negotiations, by the Claim Processor's vendor, arising from a Balance Bill Amount. Total reimbursement will never exceed the provider's actual charge. The Negotiated Amount is subject to the Exclusions and Limitations section of this Plan Document.

Negotiated Fee: A rate negotiated with a healthcare provider before services are rendered.

Nonpreferred Provider (Out-of-Network): Providers of health care services that are not Preferred Providers.

Nutritional Counseling: An individually designed service which provides an assessment of the Participant's nutritional needs and food patterns, and the planning for the provision of food and drink appropriate for the Participant's conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs.

Out-of-Network Rate: The final payment amount under this Plan for Covered Charges from a Nonpreferred Provider is:
1. Subject to 3. below, in a State that has in effect an applicable specified State law, the amount determined in accordance with such law.
2. Subject to 3. below, if no applicable specified State law:
   a. Subject to 2.b. below, the agreed amount if the Nonpreferred Provider and this Plan agree on an amount of payment (including if the amount agreed upon is the initial amount paid by this Plan or is agreed through negotiations); or
   b. The amount determined by the Certified IDR Entity.
3. In a State that has an all-payer model agreement that applies to this Plan, the provider, and the item or service, the amount that the State approves under the all-payer model agreement for that item or service.

Out-of-Pocket Limit: The amount of Covered Charges that You must pay each Plan Year for each Participant. The Out-of-Pocket Limit includes Deductible, Coinsurance, Copay, access fees and Prescription Deductible, Coinsurance and Copay(s).

Outpatient: A patient who receives medical care at a Hospital but is not admitted as a registered overnight bed patient; this must be for a period of less than 24 hours.

Outpatient Surgery Access Fee: The amount, in addition to the Plan Deductible, of Covered Charges that

must be incurred by a Participant for Outpatient surgery before benefits will be paid. The Outpatient Surgery Access Fee will be met when Covered Charges: (1) are incurred for Outpatient surgery Covered Conditions; and (2) are equal to the Outpatient Surgery Access Fee shown in the Schedule of Benefits. The Outpatient Surgery Access Fee is waived if the Outpatient surgery is performed in an emergency room and the Emergency Room Access Fee applies.

Partial Confinement: Continuous treatment of Mental Illness or Nervous Disorders, substance abuse or alcohol abuse for at least 3 hours, but not more than 12 hours, in any 24-hour period.

Participant: An Eligible Employee or their Eligible Dependent whose coverage has become effective.

Physical Status Modifier: The standard modifier describing the physical status of the patient used to distinguish between various levels of complexity of an anesthesia service provided expressed as a unit with a value between zero (0) and three (3).

Physician: A licensed medical doctor; surgeon; or any other licensed practitioner required to be recognized by state law, if applicable, acting within the scope of such license, who is not a Family Member.

Plan Document (Plan): This booklet describing Your group benefits.

Plan Sponsor: The Employer.

Plan Year: The period from July 1, 2022 through June 30, 2023.

Precertification: A review process to determine whether a service will be deemed Medically Necessary. Certification (Certified) means a service was deemed Medically Necessary as a result of the Precertification review process. Any Precertification function may be performed by an agency named by Us to do them.

Preferred Provider (In-Network): Providers of health care services who have a contract in effect with a preferred provider organization which contains the terms and conditions under which members may access discounted fees and/or negotiated or scheduled reimbursement rates under plans (other than this Plan) administered by Claim Processor.

Prescription Drug(s): Drugs and medicines which are:
1. prescribed in writing by a Physician in accordance with FDA-approved usage guidelines;
2. FDA approved;
3. legally available only by a prescription;
4. dispensed through a licensed Pharmacy or Mail Order Service or administered in a Physician's office (not including sample(s)) or by Inpatient Hospital and Outpatient Hospital and non-Hospital providers and;
5. one of the following:
   a. Federal Legend Drugs;
   b. State Restricted Drugs; or
   c. Compound Medications.

Prescription Drugs include the following:

1. disposable insulin needles and syringes;
2. disposable blood/urine glucose/acetone testing agents (Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-Tape);
3. contraceptives, oral or other, whether medication or device, regardless of intended use; and
4. Specialty Drugs.

Qualifying Payment Amount:
1. For items or services furnished during 2022, the Median Contracted Rate on January 31, 2019;
2. For items or services furnished after 2022, the Median Contracted Rate in the immediately preceding year;
3. For items or services for which there is insufficient information to calculate the Median Contracted Rate, the Qualifying Payment Amount will be calculated by identifying the rate that is equal to the median of the In-Network allowed amounts for the same or similar item or service provided in the geographic region in the year immediately preceding the year in which the item or service is furnished determined through the use of any eligible database;

The amount in 1., 2., or 3. above is increased for inflation in accordance with the CPI-U published by the Bureau of Labor Statistics of the Department of Labor.

4. For items or services furnished during 2022 and billed under a new service code where there is insufficient information to calculate the Median Contracted Rates, a reasonably related service code that existed in the immediately preceding year will be identified.
   a. If the Centers for Medicare & Medicaid Services has established a Medicare payment rate for the item or service billed under the new service code, the Qualifying Payment Amount will be calculated by first calculating the ratio of the rate that Medicare pays for the new service code compared to the rate that Medicare pays for the related service code. This ratio is then multiplied by the Qualifying Payment

Amount for the related service code for the year in which the item or service is furnished.

b. If the Centers for Medicare & Medicaid Services has not established a Medicare payment rate for the item or service billed under the new service code, the Qualifying Payment Amount will be calculated by first calculating the ratio of the rate that this Plan reimburses for the new service code compared to the rate this Plan reimburses for the related service code. This ratio is then multiplied by the Qualifying Payment Amount for the related service code.

5. For items or services furnished after 2022 and billed under a new service code, the Qualifying Payment Amount described in subsection 4. above will be increased for inflation in accordance with the percentage increase in the CPI-U published by federal regulators.
6. For anesthesia services furnished during 2022, the Median Contracted Rate for the Anesthesia Conversion Factor on January 31, 2019 increased for inflation in accordance with the increase in the CPI-U published by federal regulators (referred to as the indexed Median Contracted Rate for the Anesthesia Conversion Factor), multiplied by the sum of the Base Unit, time unit (measured in 15-minute increments or a fraction thereof), and Physical Status Modifier unit. For anesthesia services furnished during 2023 or later, the indexed Median Contracted Rate for the Anesthesia Conversion Factor will be based on the same or similar item or service in the immediately preceding year.
7. For air ambulance services billed using air mileage services codes (A0435 and A0436), the Median Contracted Rate increased for inflation in accordance with the increase in the CPI-U published by federal regulators (referred to as the indexed median Air Mileage Rate), multiplied by the number of loaded miles (the number of miles a patient is transported in the air ambulance vehicle). The Qualifying Payment Amount for other service codes associated with air ambulance services is calculated consistent with 1. through 5. above.
8. For any other items or services where payment is determined by multiplying a Contracted Rate by another unit value, the Qualifying Payment Amount for such items or services will be based on a calculation methodology similar to 6. and 7. above.

Reasonable Fee: The Reasonable Fee is subject to applicable Coinsurance and Deductibles.

1. For Inpatient Hospital and Facilities, including but not limited to birthing centers, Hospice Care, and Rehabilitation Facilities, the Reasonable Fee is the lesser of:
   a. the provider's actual charge; or
   b. the greater of:
      i. the Negotiated Fee; or
      ii. 150% of the Medicare reimbursement rate in effect at the time services were provided, or an equivalent of what Medicare would reimburse based on the use of Medicare data and independent relative value unit or other data, for the services reported on the claim, established utilizing the most currently available reimbursement schedules and methodologies.
2. For Outpatient Hospital and Facilities, including, but not limited to, birthing centers, dialysis Facilities, Free-Standing Surgical Centers, Home Health Care, Hospice Care, Nursing Care Facilities, and Urgent Care Centers the Reasonable Fee is the lesser of:
   a. the provider's actual charge; or
   b. the greater of:
      i. the Negotiated Fee; or
      ii. 130% of the Medicare reimbursement rate in effect at the time services were provided, or an equivalent of what Medicare would reimburse based on the use of Medicare data and independent relative value unit or other data, for the services reported on the claim, established utilizing the most currently available reimbursement schedules and methodologies.
3. For professional services and emergency transport via ground ambulance, the Reasonable Fee is the lesser of:
   a. the provider's actual charge; or
   b. the greater of:
      i. the Negotiated Fee; or
      ii. 130% of the Medicare reimbursement rate in effect at the time services were provided, or an equivalent of what Medicare would reimburse based on the use of Medicare data and independent relative value unit or other data, for the services reported on the claim, established utilizing the most currently available reimbursement schedules and methodologies; or
      iii. in the case of two or more co-surgeons, the Medicare reimbursement rate referenced in subsection 3.b.ii. above is multiplied by a factor of 1.25 and the resulting amount is divided equally between each co-surgeon.
4. For Prosthetics and Medical Equipment (Durable and Non-Durable), the Reasonable Fee is the lesser of:
   a. the provider's actual charge; or
   b. the greater of:
      i. the Negotiated Fee; or
      ii. 110% of the Medicare reimbursement rate in effect at the time services were provided, or an equivalent of what Medicare would reimburse based on the use of Medicare data and independent relative value unit or other data, for the services reported on the claim, established utilizing the most currently available reimbursement schedules and methodologies.
5. For Prescription Drugs or Specialty Drugs purchased without a Prescription Drug card, the Reasonable and Customary Fee is the lesser of:
   a. the Pharmacy's actual charge; or

b. 100% of the Average Wholesale Price determined by the manufacturer and published in, and updated weekly by, an industry-wide data system that collects manufacturers' prices; and
c. is exclusive of any drug manufacturer rebates.

Compound Medications will be considered at 100% of the Average Wholesale Price of the Compound's most expensive Federal Legend Drug or State Restricted Drug.

6. For injectable therapy and services, the Reasonable Fee is the lesser of:
   a. the provider's actual charge; or
   b. the greater of:
      i. the Negotiated Fee; or
      ii. the lesser of:
         a) 130% of the Medicare reimbursement rate in effect at the time services were provided, or an equivalent of what Medicare would reimburse based on the use of Medicare data and independent relative value unit or other data, for the services reported on the claim, established utilizing the most currently available reimbursement schedules and methodologies; or
         b) the Average Wholesale Price as determined by the manufacturer and published in and updated weekly by an industrywide data system that collects manufacturer's prices, plus 11%.
7. For clinical laboratory services not provided in an Inpatient or Outpatient Facility, the Reasonable Fee is the lesser of:
   a. the provider's actual charge; or
   b. the greater of:
      i. the Negotiated Fee; or
      ii. 110% of the Medicare reimbursement rate in effect at the time services were provided, or an equivalent of what Medicare would reimburse based on the use of Medicare data and independent relative value unit or other data, for the services reported on the claim, established utilizing the most currently available reimbursement schedules and methodologies.

Recognized Amount: With respect to Covered Charges furnished by a Nonpreferred Provider:

1. Subject to paragraph 3. of this definition, in a State that has in effect an applicable specified State law, the amount determined in accordance with such law;
2. Subject to paragraph 3. of this definition, in a State that does not have in effect an applicable specified State law, the lesser of:
   a. The provider's actual charge; or
   b. The Qualifying Payment Amount;
3. In a State that has an all-payer model agreement that applies to this Plan, the provider, and the item or service, the amount that the State approves under the all-payer model agreement for that item or service.

Rehabilitation Facility: A Facility that provides highly intensive acute and sub-acute Rehabilitative Services with access to 24-hour nurse support, close Physician supervision, and frequent, intensive Rehabilitative Services.

Rehabilitative Services: Medically Necessary health care services that help a Participant get back, keep, or improve skills for daily living that have been lost or impaired after being sick, hurt, or Disabled. These services assist individuals in improving or maintaining, partially or fully, skills and functioning for daily living. Rehabilitative Services include, but are not limited to, physical therapy, occupational therapy, speech-language pathology and audiology, and psychiatric rehabilitation.

Sickness: Illness, disease or Complications of Pregnancy which cause a covered loss while a Participant's coverage is in force; and for any Comprehensive Medical Benefits, congenital defects, birth abnormalities and prematurity of a covered newborn child.

Specialty Drug(s): Certain Prescription Drugs are identified as Specialty Drugs due to their cost, composition, storage requirements, and/or methods of administration. A list of Specialty Drugs is available through the website and Customer Service phone number on the Participant's ID card. If a Specialty Drug is also listed on a Formulary, it shall be covered as a Specialty Drug.

Stability Period: The period of time as determined by the Employer and consistent with Federal law, regulation and guidance, after the initial or standard Measurement Period has been completed.

Stabilize: To provide medical treatment of an Emergency Medical Condition as necessary, to assure within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the Participant from a Facility, including delivery with respect to a pregnant woman who is having contractions.

State Restricted Drug(s): Any drug which is legally available only by prescription under state law.

Telemedicine Services: Telephone or web-based video consultations and health information provided by a state licensed Physician. Such services include telebehavioral health for Mental Illness or Nervous Disorders provided by a Physician or other licensed provider.

Telemedicine Services Vendor: The designated Telemedicine Services Vendor is Teladoc®.

Unbundling: Charges for any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

Urgent Care Center: A Facility, other than a Physician's office, an emergency Facility or a Facility physically attached to a Hospital emergency room, that provides Covered Charges that are required to prevent serious deterioration of the Participant's health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Variable Hour Employee: An employee as defined by Federal law, regulation and guidance.

We, Us and Our: The Plan Sponsor/Plan Administrator.

You and Your: The Participant named on the first page of this Plan Document.

B. COVERED CHARGES

We will provide benefits for the following Covered Charges incurred after the Deductible has been met. Benefits will be paid at the Coinsurance shown in the Schedule of Benefits subject to the Reasonable Fee where applicable.

Covered Charges:

1. Room, board, intensive care unit charges, miscellaneous services and supplies, including general and skilled nursing care for each day of confinement as an Inpatient in a Hospital, including confinement solely for dental care or treatment.
2. Miscellaneous services and supplies furnished by a Hospital or a Free Standing Surgical Center and related to Outpatient surgery. This benefit is paid only for expense incurred on the date the surgery is performed.
3. Services and supplies for Outpatient treatment of Sickness or Injury provided in connection with a Covered Charge. This includes a period of observation in an observation unit or recovery room of a Hospital.
4. Physician's fees. The following Physician's fees are limited as follows:
    a. Benefits for treatment by manual or mechanical means of structural imbalance, distortion or subluxation in the vertebral column or elsewhere will be limited as shown in the Schedule of Benefits. Treatments that are not Medically Necessary are not covered.
    b. Benefits for treatment of Mental Illness or Nervous Disorders, substance abuse and alcohol abuse may be limited if shown under Benefit Maximums in the Schedule of Benefits for Participants covered under a small group health benefit plan.
    c. Assistant surgeon expenses are limited to 20% of the Reasonable Fee for the surgical procedure for which services are rendered.
5. Registered graduate nurse (R.N.) and licensed practical nurse (LPN) fees for private duty nursing care when recommended by a Physician. In-Hospital private nursing services are covered only if the Hospital's regular staff can't provide the care needed due to the nature of the Participant's condition.
6. Local professional ambulance service to or from a Hospital. "Local" means the metropolitan area in which the Participant is located at the time service is used. If the Participant is in a rural area, "Local" means the nearest metropolitan area; transportation to and from the nearest Hospital with facilities for required special treatment including professional ambulance services and railroad or regularly scheduled airline fares. Ambulance service cannot be for the Participant's convenience, the Participant's Physician or the Participant's family's convenience. It must be Medically Necessary.
7. Speech therapy for speech loss or impairment due to a Sickness or Injury other than a functional nervous disorder, or due to surgery performed on account of a Sickness or Injury. If speech loss is due to congenital anomaly, surgery to correct the anomaly must have been performed prior to the speech therapy. Benefits for speech therapy are limited as shown in the Schedule of Benefits. Treatments that are not Medically Necessary are not covered.
8. The following Covered Charges when prescribed by a Physician and not included in 1. through 7. above:
    a. anesthetics and their administration;
    b. physical and occupational therapist's fees. Benefits for physical and occupational therapy are limited as shown in the Schedule of Benefits, however, treatments that are not Medically Necessary are not covered;
    c. x-rays (but not dental x-rays) and laboratory tests done for diagnosis or treatment;
    d. x-ray, cobalt, radioactive isotope therapy, radiation therapy, chemotherapy, and advanced imaging services, including but not limited to Computed Tomography (CT) and Computed Tomography Angiogram (CTA), Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA), Nuclear Cardiology Imaging (NCI), Positron Emission Tomography (PET) and Positron Emission Tomography Computed Tomography (PET CT), and 3D Rendering;
    e. blood and blood plasma;
    f. Chronic Pain treatment. Benefits for Chronic Pain treatment are limited as shown in the Schedule of

Benefits;

g. Prosthetics and Durable Medical Equipment: The purchase of prosthetics and the rental of Durable Medical Equipment as Medically Necessary, including:
   i. Artificial limbs and eyes;
   ii. Crutches; canes; walkers; braces, including necessary adjustments to shoes to accommodate braces (except that dental braces are not included);
   iii. Basic wheelchairs;
   iv. Basic Hospital-type bed (except that repair, replacements and duplicates are not included);
   v. Oxygen and the rental of equipment for the administration of oxygen;
   vi. Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air conditioners, humidifiers, dehumidifiers, and other personal comfort items are not included).

   Durable Medical Equipment must be provided by or under the direction of a Physician.

   Durable Medical Equipment may be purchased as determined by Us.

9. Prescription Drugs
10. Preventive services will be paid in accordance with the following guidelines:
    a. U.S. Preventive Services Task Force
    b. Health Resources and Services Administration
    c. Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention

Preventive services are subject to change as required by the Affordable Care Act. Recommended populations, age and frequency schedules apply. A complete list of Preventive services can be found at: www.healthcare.gov/preventive-care-benefits and www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

In no event will benefits provided for Preventive services be less than that which is required by federal law. The Plan may use reasonable medical management techniques to determine appropriate frequency, method or setting for a Preventive service to the extent such service is not specified in the guidelines or recommendations.

Preventive services include, but are not limited to:

- Routine physical exam;
- Blood and other laboratory tests;
- Cholesterol screening;
- Depression screening;
- Obesity screening and counseling;
- Osteoporosis screening (bone density screening);
- Screening ECG (electrocardiogram) for Participants over age 40 who have 2 or more cardiac risk factors;
- Immunizations;
- PSA (prostate-specific antigen) for males ages 40 or older;
- Colorectal cancer screening, including pre-procedure consultation, bowel preparation kits and pathology exam;
- Screening for tobacco use. Coverage for two tobacco cessation attempts per year and tobacco cessation medications for a 90-day treatment regimen when prescribed by a Physician.

Women's Preventive Services include:

- Well-woman visits, including routine prenatal office visits;
- Screening for gestational diabetes;
- Screening for cervical cancer (pap smear every 3 years, ages 21-65; or for women ages 30-65 who want to lengthen the screening interval, pap smear and human papillomavirus (HPV) testing every 5 years);
- Counseling for sexually transmitted infections;
- Counseling and screening for human immunodeficiency virus;
- Contraceptive methods and counseling;
- Breastfeeding support, supplies, and counseling;
- Screening and counseling for interpersonal and domestic violence;
- Baseline mammogram between the ages of 35-39 and an annual mammogram at age 40 or older;
- Breast Cancer Genetic Test (BRCA): Counseling about genetic testing for breast cancer (must be at higher risk), and, if indicated for harmful BRCA mutations.

11. Covered Charges for a mastectomy, coverage includes:
    a. Reconstruction of the breast on which the mastectomy has been performed, including nipple and areola reconstruction and repigmentation;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c. Prostheses and treatment for physical complications of all stages of mastectomy, including lymphedemas.
12. Off-label use of a drug recognized for treatment in any of the standard reference compendia or in the medical literature. Coverage of a drug also includes Medically Necessary services associated with the

administration of the drug. This does not include Experimental/Investigational drugs not approved by the FDA.

13. Administration of general anesthesia and Hospital charges for dental care provided to the following Participants:
    a. a child under the age of 5;
    b. a Participant who is severely Disabled; or
    c. a Participant who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
14. Coverage for routine patient cost of Approved Clinical Trials, excluding:
    a. the investigational item, device, or service, itself;
    b. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
    c. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

    This coverage is only available to those Participants who are eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.
15. Equipment, supplies and Outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes.

    Covered diabetes Outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes.

    Covered Outpatient self-management training and education will be limited to:
    a. a one-time evaluation and training program when Medically Necessary, within 1 year of diagnosis; and
    b. additional Medically Necessary self-management training will be provided upon a significant change in symptoms, condition or treatment. This additional training will be limited to 3 hours per year.
16. Acupuncture, Massage Therapy, Naturopathic Medicine and Nutritional Counseling when provided by a certified or licensed provider.
17. Emergency Services.
18. Habilitative and Rehabilitative Services.
19. Habilitative and Rehabilitative Devices.
20. Telemedicine Services including web-based video consultation services and telephone consultation services. Availability of Telemedicine Services provided through the designated Telemedicine Services Vendor may vary by state. Telebehavioral health services for Mental Illness or Nervous Disorders provided through the designated Telemedicine Services Vendor are not available to a Participant who is under the age of 18 years and in states where the age of majority is greater than 18 years, parental consent may be required.
21. Hair prosthesis for alopecia resulting from cancer treatment that involves chemotherapy or radiation therapy.
22. Treatment provided during Partial Confinement will be considered as treatment provided on a Hospital Inpatient basis.
23. Gender dysphoria. Covered Charges include treatment provided by a Physician for gender dysphoria, a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Treatment includes Medically Necessary psychotherapy, hormone therapy, Prescription Drugs and surgery. Cosmetic services, including the following, are not covered:
    - Abdominoplasty
    - Blepharoplasty
    - Breast enlargement, including augmentation mammoplasty and breast implants
    - Body contouring such as lipoplasty or liposuction
    - Brow lift
    - Calf implants
    - Cheek, chin, nose implants
    - Electrolysis
    - Injection of fillers or neurotoxins
    - Face lift, forehead lift or neck tightening
    - Facial bone remodeling
    - Hair removal
    - Hair transplantation
    - Jaw reduction or jaw contouring
    - Laryngoplasty
    - Lip augmentation
    - Lip reduction
    - Mastopexy
    - Pectoral implants for chest masculinization
    - Removal of redundant skin
    - Rhinoplasty

- Skin resurfacing
- Thyroid cartilage reduction
- Voice modification surgery
- Voice lessons and voice therapy

C. APPLICATION OF DEDUCTIBLE

1. The Deductible is shown in the Schedule of Benefits.
2. If two or more covered members of Your family are injured in the same accident, only one Deductible will be applied to all Covered Charges, combined for all Participants, arising out of the accident during the year.
3. A Deductible separate from the mother's must be met for a covered newborn child.
4. Covered Charges incurred by one Participant shall not be used to meet the Deductible for any other Participant. The only exceptions to this are set forth in 2. above and in the Schedule of Benefits.
5. Payments made for Negotiated Amounts will not apply toward the Deductible.

D. MAXIMUM AMOUNTS

1. Refer to the Benefit Maximums listed in the Schedule of Benefits.

2. The Out-of-Pocket Limit is the amount You must pay each Plan Year for each Participant. The Out-of-Pocket Limit does not include any Precertification penalties or payments made for Negotiated Amounts.

   When the maximum Out-of-Pocket Limit is reached, Covered Charges for similar services will be paid at 100% until the end of the Plan Year except as otherwise noted.

3. The Copay does not apply toward the Deductible but does apply toward the Out-of-Pocket Limit. After the Copay is paid, We will pay 100% of the Covered Charges up to the applicable limits as shown in the Schedule of Benefits. Additional Covered Charges are subject to the Deductible and Coinsurance. The Copay is shown in the Schedule of Benefits.

E. COPAY

Physician Office Visit
After the Copay, this Plan pays 100% of Covered Charges for Physician office visits, which include professional services for evaluation and management, non-surgical injections, including professional fees for allergy injections billed by the attending Physician. The Physician office visit does not apply to laboratory and radiology services, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), chemotherapy, allergy testing and allergy serum, preventive care procedures or any surgical procedure resulting from Sickness or Injury.

Emergency Services
After the Copay, this Plan pays 100% of Covered Charges for Physician and Facility charges for services received while a patient in the emergency room. The Copay will not be waived if the Participant is admitted to the Hospital following an emergency room visit. Non-emergency treatment received in the emergency room will be paid subject to Deductible and Coinsurance.

Urgent Care Center Visit
After the Copay, this Plan pays 100% of Covered Charges for Physician and Facility charges for services received while a patient in the Urgent Care Center. Covered Charges do not include magnetic resonance imaging (MRI) or computerized axial tomography (CAT scan).

Speech, Physical, Occupational Therapy
After the Copay, this Plan pays 100% of Covered Charges for speech, physical and occupational therapy, subject to the maximum number of visits as shown in the Schedule of Benefits. There is an additional Copay for such therapy received in a Physician's office – one for the Physician office visit and one for the therapy. If the therapy is received as an Outpatient in a Hospital, the charges are subject to the Deductible and Coinsurance, but the visit will count toward the maximum number of visits.

Manipulation Therapy
After the Copay, this Plan pays 100% of Covered Charges for manipulation therapy, subject to the maximum number of visits as shown in the Schedule of Benefits. Covered Charges do not include Diagnostic x-rays, lab charges, magnetic resonance imaging (MRI) or computerized axial tomography (CAT scan).

Outpatient Advanced Imaging
After the Copay, this plan pays 100% of Covered Charges per procedure (includes professional and

technical components). The Outpatient advanced imaging Copay shown in the Schedule of Benefits will not apply when services are performed in an Emergency Room or Urgent Care Center.

F. EXCLUSIONS AND LIMITATIONS

1. The following exclusions and limitations will apply only to the extent permitted by the Patient Protection and Affordable Care Act of 2010 and corresponding regulations:
   - services or supplies not Medically Necessary, not performed or not required for the Covered Condition;
   - charges in excess of the Reasonable Fee for the services or supplies, except for any Negotiated Amount;
   - services or supplies not prescribed by a Physician as required to treat the Covered Condition;
   - dental care or treatment of any kind including treatment of the gums and supporting structures and related medical care, services and supplies; this exclusion does not apply to damage to natural teeth caused solely by Injury (except chewing injuries);
   - surgery of the jaw (orthognathic);
   - eyeglasses, eyeglass frames, all types of contact lenses or corrective lenses; eye exercises, visual training, orthoptics, radial keratotomy, laser surgeries and other refractive keratoplasties; refractions (test to determine if eyeglasses are needed); and all other vision care services, except as otherwise specified in this Plan Document;
   - services and supplies related to hearing care, including ear plugs, external BAHA devices, hearing aids and adjustments, except as otherwise specified in this Plan Document;
   - oral appliances for snoring or medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea;
   - hair prosthesis except as otherwise specified in this Plan Document, hair transplants;
   - medical and surgical treatment of excessive sweating (hyperhidrosis);
   - cosmetic surgery; including surgery of the eyelid (Blepharoplasty); this does not apply to Covered Charges for: (a) correction of damage caused by Injury or Sickness or (b) congenital deformities of a newborn child;
   - loss due to war, or act of war, declared or undeclared;
   - loss due to the Participant's participation in a riot;
   - loss which occurs during or as a result of the Participant's participation in the commission of, or attempt to commit a felony;
   - services, supplies, care or treatment given to a Participant for treatment of an Injury or Sickness sustained while:
     - the Participant is under the influence of illegal narcotics or a non-prescribed controlled substance; or
     - the Participant is under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of, and in accordance with the direction of a Physician; or
     - the Participant is driving with an illegal alcohol level; or
     - the Participant is misusing over the counter medication, or misusing any other drug or substance that can be purchased without a Physician's written prescription.

     This exclusion will not apply if the Injury or Sickness resulted from an act of domestic violence or an underlying medical condition. Covered Charges will be paid for injured Participants who were other than the person illegally using alcohol;
   - loss to which a contributing cause was the Participant engaging in an illegal occupation;
   - charges the Participant is not legally required to pay, including charges in the absence of coverage for services or supplies provided, or paid for by, any federal, state or local government (except under Medicaid) or services previously billed as part of a related service and not considered reasonable and necessary by the Centers for Medicare and Medicaid Services or any successor organization;
   - charges for missed or canceled appointments, stand-by charges or after hours, surcharges for weekend office visits that are not an emergency, or home visits by a Physician;
   - services or supplies furnished by a person who usually resides in Your home or who is a Family Member;
   - items for comfort or convenience, including but not limited to television, telephone, beauty/barber services, guest services, and supplies, equipment or similar incidental services and supplies for personal comfort, such as air conditioners, air purifiers and filters, batteries, battery chargers, dehumidifiers, and humidifiers;
   - expenses incurred as part of a rest cure, or at a health spa or similar facility, except as otherwise specified in this Plan Document;
   - loss due to suicide, or attempted suicide, if the suicide/attempted suicide is not the result of a medical condition;
   - loss due to intentionally self-inflicted Injury, if the Injury is not the result of a medical condition;
   - treatment of abnormal breast enlargement in males (benign gynecomastia);
   - drugs, therapies and treatment for the restoration or enhancement of sexual activity;
   - immunizations required for travel outside the United States, x-rays or tests not related to diagnosis or treatment of Sickness or Injury;
   - Experimental/Investigational drugs, medicines, treatment, procedures and therapies;

- services and supplies related to homeopathic medicine;
- application of medications through the skin with the use of high frequency sound waves (phonophoresis);
- surface electromyogram (EMG);
- charges for family or marriage counseling, aversion therapy, and except as otherwise specified in this Plan Document, charges for training or other forms of education;
- Sickness or Injury which occurs while working for wage or profit is not covered, except for a Participant who is a sole proprietor, partner or executive officer of the Employer who is: (a) not required by law to have Workers' Compensation or similar coverage; and (b) does not have such coverage;
- treatment for weight reduction, for medical and non-medical reasons, including but not limited to: weight reduction or weight control surgical procedures, devices, regimens, treatments, therapies, services or products, also including anorectics or any drugs used for weight control, nutrition-based therapy and counseling, except as specified under Covered Charges for preventive services;
- dietary supplements, vitamins, and mega-vitamins, except for prenatal vitamins and vitamin B12 injections;
- Cryoanalgesia and therapeutic cold devices;
- any drug containing nicotine for the purpose of use as a smoking deterrent or other smoking deterrent medications, except as set forth in the Preventive Services section;
- treatment (including cutting or removal) of toe nails or superficial lesions of the feet including corns, calluses and hyperkeratosis, other than removal of nail matrix or root;
- hygienic and preventive maintenance foot care, treatment of flat feet, subluxation of the foot;
- gait analysis;
- Custodial Care;
- Pregnancy of a person who is not an Eligible Employee or Eligible Dependent including, but not limited to, a surrogate;
- reversal of sterilization;
- non-Prescription Drugs;
- Imported Drugs;
- treatment of infertility, not including services related to the diagnosis of infertility, unless coverage is specifically added to this Plan Document;
- treatment, Prescription Drugs, services or supplies provided by a medical department, treatment center, Pharmacy or clinic operated by or sponsored by a Participant's Employer;
- Charges for treatment, services, supplies or Prescription Drugs designed or used to diagnose, treat, alter, impact, or differentiate a Participant's genetic make-up or genetic predisposition, including but not limited to Genetic Therapy.

2. **No** benefits will be paid under this Plan for, services or supplies that a Participant received before his effective date of coverage under this Benefit.
3. **No** benefit will be paid under this Plan for, services or supplies that a Participant received after the date his coverage terminated under this Plan.
4. Benefits will be limited as follows.
   a. Dental procedures to correct TMJ are not covered.
   b. Benefits for prosthetic devices are limited to the initial device, unless required due to progression of a Sickness or Injury or growth of a child.
   c. Benefits for Mental Illness or Nervous Disorders, substance abuse and alcohol abuse may be limited as shown in the Schedule of Benefits.
5. No benefits are payable for any medical treatment other than treatment for emergencies outside the United States.

SKILLED NURSING CARE BENEFIT

A. DEFINITIONS

Custodial Care: Services and supplies provided to You or Your Dependent, whether or not Disabled, which are not intended to contribute greatly to the improvement of the medical condition according to generally accepted standards. Such care includes, but is not limited to: (1) assisting the Participant to walk, get in and out of bed, bathe, dress, prepare special diets, supervise medicine which can usually be self-administered and which does not require the attention of medical or paramedical personnel; and (2) assisting the Participant in other activities of daily life. Such care is custodial without regard to the provider by which it is prescribed, referred or performed.

Nursing Care Facility: A lawfully operated Facility which: (1) provides full-time bed care for resident patients; (2) provides 24 hour nursing service by, or supervised by, a registered graduate nurse (R.N.) or licensed practical nurse on duty at all times; (3) regularly provides skilled nursing care supervised by a Physician; and (4) keeps a daily medical record of each patient. Nursing Care Facility does not include: a Hospital; or a rest home or home for the aged; or a Custodial Care or educational care facility.

B. BENEFITS

Benefits will be paid for Covered Charges for pre certified skilled nursing care by You or Your Dependent while coverage is in force. Benefits will be paid for Nursing Care Facility charges for room, board and miscellaneous fees for service and supplies required due to Sickness or Injury. Benefits will only be paid for a confinement which follows within 3 days release from a Hospital; or which follows surgery which requires skilled nursing care. Benefits will be paid up to the maximum number of days shown in the Schedule of Benefits.

C. EXCLUSIONS

No benefits will be paid for intermediate level nursing care or Custodial Care.

HOME HEALTH CARE BENEFIT

A. DEFINITIONS

Home Health Care: The services listed below which: (1) are provided in the home by a licensed or Medicare certified home health agency; (2) are required for the care or treatment of Sickness or Injury; and (3) are given on the written request of a Physician.

Home Health Care services include: Nursing services; home health aide services consisting mainly of care of the patient and services provided by licensed physical, occupational, speech, nutrition, inhalation or respiratory therapists.

B. BENEFITS

Benefits will be paid for Covered Charges for pre certified Home Care Services incurred by You or Your Dependent while coverage is in force. Benefits will be paid up to the maximum number of days shown in the Schedule of Benefits.

C. EXCLUSIONS

No benefits are paid for:
1. food, housing, homemaker services, home-delivered meals;
2. any services not listed above as a benefit;
3. services or supplies not included in the home care plan established for the patient;
4. services provided by the patient's spouse, parent, brother, sister, child, spouse's parent, or anyone residing with the patient.

HOSPICE CARE BENEFIT

A. DEFINITIONS

Hospice Care: The services listed below which are provided:
1. by a licensed or certified hospice or by any other medically appropriate Facility;
2. to terminally ill Participants who have, as certified by a Physician, a life expectancy of not more than 6 months;
3. for the purpose of palliative control of pain and not for cure; and
4. are given on the written request of a Physician.

Hospice Care includes: services of Physicians, nurses, home health aides and physical, occupational, speech, nutrition, inhalation or respiratory therapists acting within the scope of their practice and providing services directly to the patient; room and board charges; and other medical services and supplies required under the Hospice Care plan.

B. BENEFITS

Benefits will be paid for Covered Charges for pre certified Hospice Care incurred by You or Your Dependent while coverage is in force. Benefits will be paid up to the maximum shown in the Schedule of Benefits.

C. EXCLUSIONS

No benefits will be paid for care which no charge would be made in the absence of this Hospice Care Benefit.

PRESCRIPTION DRUGS FOR CANCER TREATMENT BENEFIT

A. DEFINITION

Prescription Drugs for Cancer Treatment: Drugs prescribed by a Physician, whether or not they have been

approved by the U.S. Food and Drug Administration (FDA) for the treatment of the specific type of cancer for which the drug has been prescribed. The drug, however, must be approved by the FDA and it must also be recognized for treatment of that specific type of cancer in any one of the following:
1. the American Medical Association Drug Evaluation;
2. the American Hospital Formulary Service Drug Information; or
3. the United States Pharmacopedia Drug Information.

If not listed in any of the above compendia, the drug must be recommended for that specific type of cancer in formal clinical studies. The results of the clinical studies must have been published in at least two peer reviewed professional medical journals published in the United States or Great Britain.

B. BENEFITS

Benefits will be paid for Covered Charges incurred by You or Your Dependent for Prescription Drugs used for the treatment of cancer.

C. EXCLUSION

No benefits will be paid for Experimental/Investigational cancer drugs or any cancer drug that the FDA has determined to be contraindicated for treatment of the specific type of cancer for which the drug was prescribed.

PREGNANCY AND ROUTINE NURSERY CARE BENEFIT

This Benefit Applies Only If The Schedule of Benefits Shows That You Have Pregnancy and Routine Nursery Care Coverage.

A. DEFINITIONS

Pregnancy: The condition of a pregnant woman from the time of conception until the birth of her baby.

Elective Abortion: Abortion other than:
1. abortion performed when the Participant's life or health would be endangered if the abortion was not done;
2. abortion performed when the Pregnancy results from rape or incest; or
3. spontaneous abortion.

Routine Nursery Care: Means room, board and general nursing care provided while a covered well newborn child is confined in a Hospital following birth.

B. BENEFITS

Regardless of any exclusions in the Comprehensive Medical Benefit section to the contrary, benefits will be paid for Covered Charges incurred for Pregnancy or Elective Abortion by You or Your Dependent while coverage is in force.

Covered Charges include:
a. Pre-natal and post-natal care and delivery;
b. Routine Nursery Care;
c. Physician fees for the first visit to examine a newborn in the Hospital following birth;
d. Physician fees for circumcision of a newborn; and
e. Elective Abortion services.

Covered Charges will include a minimum of 48 hours in the Hospital following a vaginal delivery or 96 hours following a cesarean, unless the Participant and the Participant's Physician agree on an earlier discharge. In the event of any early discharge, the Participant will be entitled to one follow-up visit within 48 hours of discharge from the Hospital. The Participant may choose to have this visit take place at the Participant's home or the Participant's Physician's office. During the visit, services may include, but are not limited to, physical assessment of the newborn, parent education, assistance training in breast or bottle feeding, assessment of the home support system, and the performance of any Medically Necessary and appropriate clinical tests consistent with protocols and guidelines developed by national pediatric, obstetric and nursing professional organizations for such services.

Benefits will be paid as shown in the Schedule of Benefits.

ONCOLOGY MANAGEMENT PROGRAM

The purpose of this oncology management program is to assist the Participant and the Participant's oncologist during the Participant's course of cancer treatment when administered in either an Outpatient setting (e.g. in

the Physician's office or other covered Outpatient setting) or an Inpatient setting. The program only applies to the chemotherapy plan of treatment and other oncology pharmaceuticals to be used in connection with the Participant's cancer treatment.

In order to initiate the oncology management process, the Participant or the Participant's attending Physician should contact Us to verify Plan benefits. The plan of treatment shall also be Precertified by calling the telephone number for Precertification shown on the Participant's identification card. Failure to follow the Precertification procedures outlined under the Precertification Requirement section of this Plan will result in a per occurrence Precertification penalty, as shown in the Schedule of Benefits.

A certified oncology nurse or Oncology Nurse Specialist (ONS) will be assigned to the Participant's case. The ONS will contact the Participant periodically to provide support, education, and answer any questions. At the same time, the ONS will contact the oncologist to discuss the proposed plan of treatment and assist in coordinating the subsequent information pertaining to the various cycles of the plan of treatment. In addition, clinical oncology pharmacists will be available to the Participant and the Participant's oncologist on a twenty-four (24) hour seven (7) day a week basis by contacting 1-800-983-1590. The Participant is encouraged to call this number if he/she has questions regarding the cancer drugs being used in the Participant's plan of treatment, related side effects and other quality of life issues.

If the Participant's oncologist determines that oral anti-cancer drugs and/or supportive medications should be taken in the home setting following the chemotherapy treatment received on an Inpatient or Outpatient basis, the Participant's oncologist may require that the drugs be sent to the Participant's home in time to meet the medication schedule specified by the Participant's oncologist. A clinical oncology pharmacist will call the Participant to discuss the medications and answer any questions he/she has about the specific drugs to be taken in the home.

Unless the Participant's treating oncologist has entered into an agreement with the oncology management program to accept other reimbursement rates, reimbursement for all Covered Charges for drugs used in the treatment of cancer shall be limited to the rate of Average Sales Price (ASP) plus 10%.

Average Sales Price (ASP) means the average sales price, updated quarterly by Medicare under the Medicare Part B drug payment system.

In order to receive reimbursement under this Plan, the oncologist's plan of treatment must be reviewed and approved by the oncology management program. If any of the drugs prescribed by the Participant's oncologist requires specific pathology results or molecular marker results to validate their use, these results must be provided to the oncology management program prior to validation of the Participant's treatment regimen.

This Plan will not pay for or otherwise cover the cost of drugs considered Experimental/Investigational by Us.

Notwithstanding this Plan's definition and exclusions of Experimental/Investigational, in the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental/Investigational if (1) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs and the oncology management program's Compendium, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints or Clinical Pharmacology or (2) the drug is provided in association with a Phase III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute (NCI) or (3) the drug is provided in association with a Phase II trial for cancer by an NCI-sponsored group and standard treatment has been or would be ineffective or does not exist or there is no clearly superior non-investigational alternative that can be delivered more cost efficiently as determined by Us.

PRECERTIFICATION AND NOTIFICATION REQUIREMENT

A. EFFECT OF PRECERTIFICATION ON BENEFITS

In the event the Precertification process determines a proposed service is not Medically Necessary according to the terms of this Plan Document, the Participant and the attending Physician will be advised in accordance with the Timing of Claim Determinations for Pre-Service Claims provision of the Claim Review and Appeals section of this Plan Document. No benefits will be payable for such services if they are in fact rendered.

If care or services are received for which Precertification was not attempted, a retrospective review to determine the Medical Necessity of such service may be conducted. If such services are determined to be Medically Necessary, a per occurrence Precertification penalty will be assessed. No benefits are payable for services determined to be not Medically Necessary. The Precertification penalty is shown in the Schedule of Benefits.

Precertification does not guarantee that benefits are payable. The Participant must be eligible for Covered Charges under the terms of this Plan Document in order to receive benefits.

B. PRECERTIFICATION PROCEDURES

The following non-Emergency Services are subject to Precertification:
1. Inpatient Hospital stays;
2. organ and bone marrow transplants;
3. home health care;
4. home infusion therapy, Outpatient radiation and chemotherapy; or home infusion therapy including chemotherapy;
5. hospice;
6. acute Inpatient rehabilitation stays;
7. long-term acute rehabilitation stays;
8. sub-acute Inpatient medical and rehabilitation stays;
9. skilled nursing stays;
10. Inpatient and residential Mental Illness or Nervous Disorders, substance abuse and alcohol abuse;
11. Outpatient advanced imaging; imaging services, including new technology, but not limited to, Computed Tomography (CT) and Computed Tomography Angiogram (CTA), Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA), Nuclear Cardiology Imaging (NCI), Positron Emission Tomography (PET) and Positron Emission Tomography Computed Tomography (PET CT), and 3D Rendering.

How to Precertify: The Participant or the attending Physician must call the telephone number for Precertification shown on the identification card. The call must be made prior to the service being rendered.

Be prepared to give the following information:
1. Your name, social security number, and the group plan number;
2. patient's name and date of birth;
3. the name and address (if applicable) of the healthcare Facility, Home Health Care agency or hospice;
4. Physician's name and telephone number;
5. the diagnosis (what is wrong); and
6. the treatment (what will be done and when).

It is the Participant's responsibility to ensure that Precertification is obtained. We recommend that the Participant follow-up with the attending Physician to ensure that all medical information is provided. Confirmation of the certified treatment will be provided to the Participant, the attending Physician, and the health care Facility (if applicable). If the treatment is not Medically Necessary according to the terms of this Plan Document, the Participant will be informed in writing. The Participant or their Physician may, in accordance with the Claim Review and Appeals section of this Plan, request a reevaluation of the treatment being certified.

Certification will be valid for 60 days for the requesting Physician and the named health care Facility. A change in either will require a new certification.

C. NOTIFICATION REQUIREMENT

Notification is required within 48 hours or the next business day of an Emergency Admission by calling the number shown on the identification card.

NONPREFERRED PROVIDERS

This Plan does not utilize a PPO network; therefore, all providers are considered Nonpreferred Providers. Except as explained below, Covered Charges from Nonpreferred Providers are subject to the Reasonable Fee.

a. Covered Charges for Out-of-Network Emergency Services will be:
   1) paid based on the lesser of the Qualifying Payment Amount or the Nonpreferred Provider's actual charge; or when applicable:
      i. in a State that has in effect an applicable specified State law, the amount determined in accordance with such law; or
      ii. in a State that has an all-payer model agreement that applies to this Plan, the provider, and the item or service, the amount that the State approves under the all-payer model agreement for that item or service.

   The Participant's Cost Sharing will be calculated based on the Recognized Amount and Nonpreferred Providers may not balance bill for amounts in excess of the Participant's Cost Sharing. If the Out-of-Network Rate exceeds the Recognized Amount, the difference will not be subject to the Deductible.

b. Covered Charges for Out-of-Network air ambulance services will be:
   1) paid based on the lesser of the Qualifying Payment Amount or the Nonpreferred Provider's actual charge; or when applicable:

i. in a State that has in effect an applicable specified State law, the amount determined in accordance with such law; or
ii. in a State that has an all-payer model agreement that applies to this Plan, the provider, and the item or service, the amount that the State approves under the all-payer model agreement for that item or service.

The Participant's Cost Sharing will be calculated based on the lesser of the Qualifying Payment Amount or the billed amount, and Nonpreferred Providers may not balance bill for amounts in excess of the Participant's Cost Sharing. If the Out-of-Network Rate exceeds the lesser of the Qualifying Payment Amount or the billed amount, the difference will not be subject to the Deductible.

c. Open Negotiation Period
1) A Nonpreferred Provider may initiate an open negotiation period with this Plan regarding Covered Charges described in subsections a. above. This open negotiation period must be initiated during the 30-business day period beginning on the day the Nonpreferred Provider receives an initial payment or a notice of denial of payment for Covered Charges described in subsections a. and b. above. To initiate the open negotiation period, the Nonpreferred Provider must send notice, consistent with applicable regulations, to this Plan on a standard form developed by federal regulators.
2) The day on which the open negotiation notice is sent by the Nonpreferred Provider is the date the 30-business day open negotiation period begins. Any additional payment amount agreed upon during the open negotiation period must be made by this Plan within 30 days of such agreement and will not be subject to additional Cost Sharing.

d. Independent Dispute Resolution
1) In the case of failed negotiations, the Nonpreferred Provider or this Plan may initiate the Federal independent dispute resolution (IDR) process established under the No Surprises Act. The IDR process must be initiated, consistent with applicable Federal regulations, within 4 business days beginning on the 31st business day after the start of the open negotiation period.
2) Within 30 days after the date a Certified IDR Entity is selected, such entity must select a payment amount and notify this Plan and the Nonpreferred Provider of the determination. In the absence of a fraudulent claim or evidence of intentional misrepresentation of material facts presented to the Certified IDR Entity, the decision by such entity is binding on all involved parties.
3) Any additional payment amount due from this Plan resulting from the decision of the Certified IDR Entity:
i. will not be subject to additional Cost Sharing;
ii. must be paid within 30 days of such determination; and
iii. will result in this Plan being responsible for payment of all fees properly charged by the Certified IDR Entity.

If the Certified IDR Entity determines that no additional payment is due to the Nonpreferred Provider by this Plan, such provider will be responsible for payment of the Certified IDR Entity fee. This Plan and the Nonpreferred Provider will each be responsible for the Federal IDR administrative fee.
4) The Nonpreferred Provider and this Plan may agree on a payment amount for an item or service during the independent dispute resolution process but before the date on which the Certified IDR Entity makes a final payment determination. Such amount will be treated as the Out-of-Network Rate and to the extent this amount exceeds the initial payment amount and any Cost Sharing amount, the Plan must pay the additional amount to the Nonpreferred Provider within 30 business days from the date the agreement is reached. This Plan will be responsible for payment of half of all fees charged by the Certified IDR Entity, unless this Plan and the Nonpreferred Provider otherwise agree in writing.

PRESCRIPTION DRUG CARD BENEFIT

The Deductible and Coinsurance of the Comprehensive Medical Benefit do not apply to this Prescription Drug Card Benefit.

Section A. Definitions, of the Comprehensive Medical Benefit, apply when not otherwise defined below.

A. DEFINITIONS

Brand Name Drug: A Prescription Drug which is manufactured and marketed under a trademark or name by a specific drug manufacturer. A Prescription Drug is classified as a Brand Name Drug by the FDA as reflected in nationally recognized data sources.

Bulk Chemical Powder: A raw ingredient used to make a commercially available drug product such as tablets, capsules, creams and ointments.

Copay(s): The amount of expenses for Prescription Drugs that must be incurred by each Participant, each time a prescription is filled or refilled, before benefits are payable. The Copays, if any, are shown in the Schedule of Benefits.

Designated Pharmacy: A Pharmacy which is under contract with Claim Processor's pharmacy benefit manager used with the Prescription Drug Card benefit.

Designated Specialty Pharmacy: A Pharmacy which is under contract with Claim Processor's pharmacy benefit manager used with the Prescription Drug Card benefit for Specialty Drugs.

Emergency: A situation due to an Injury or a medical condition, which reasonably requires the Participant to seek immediate medical care under circumstances or at locations which reasonably prevent him from obtaining Prescription Drugs from a Designated Pharmacy.

Formulary: A list of drugs that have been selected by Claim Processor's pharmacy benefit manager and adopted by the Plan, for therapeutic efficacy and best cost values and are considered the agents of choice for a Physician to prescribe.

Generic Prescription Drug: A drug that has the same active ingredient or is bioequivalent to a Brand Name Drug in dosage form, safety, strength, route of administration, quality, performance characteristics, intended use and is not protected by a patent. A Prescription Drug is classified as a Generic Drug by the FDA as reflected in nationally recognized data sources. Not all Generic Prescription Drugs will be on the Formulary.

Maintenance Drugs: Prescription Drugs taken for a medical condition on a regular, routine or long term basis for care and treatment of chronic conditions which require that the dosage remain unchanged for more than 30 days. Specialty Drugs are not considered Maintenance Drugs.

Non-Designated Pharmacy: A Pharmacy which is not under contract with Claim Processor's pharmacy benefit manager used with the Prescription Card benefit.

Nonpreferred Drug: A Formulary Prescription Drug that is part of a therapeutic class on the Preferred Performance Drug List (PDL) which does not offer the best efficacy and cost effectiveness over other products in the same class or it is a product that is not listed on the Formulary.

Pharmacy: A licensed establishment where Prescription Drugs are dispensed by a pharmacist licensed under the law of the state where such pharmacist practices.

Preferred Drug: A Formulary Prescription Drug that is within a select subset of therapeutic classes constituting the preferred drug list (PDL) which offers the best efficacy and cost effectiveness over other products in the same class. Prescription Preferred Drugs are shown on the PDL furnished by the provider of the identification card used with this Prescription Drug Card benefit.

Preferred Performance Drug List (PDL): A subset of the Formulary. The PDL is not a complete Formulary but a list of Prescription Drugs from the standard Formulary that are cost effective in selected therapeutic classes. This list may not include all drugs for treatment of every illness.

Prescription Deductible: The amount, if any, for Prescription Drugs that must be incurred by each Participant in a Plan Year, before benefits are payable in addition to the Deductible. The Prescription Deductible, if any, is shown in the Schedule of Benefits.

B. IDENTIFICATION CARD

Each Eligible Employee will be given an identification card, or three cards will be given per family. The Participant must show this card each time he buys a Prescription Drug at a Designated Pharmacy. He does not have to file a claim for benefits. The Designated Pharmacy will keep track of any required Prescription Deductible which the Participant must pay, and the individual Copays, if any, required for each prescription. If a Prescription Drug is bought at a Non-Designated Pharmacy, the Participant must pay the entire cost of the drug and file a claim for benefits. The benefit may, in such cases, be lower than if he had bought the drug at a Designated Pharmacy and shown his card.

C. BENEFITS

Benefits are considered for Prescription Drugs when subject to the Prescription Deductible, Copay and Reasonable Fee where applicable. Manufacturer coupons or copay cards will not be applied toward the satisfaction of a Participant's Deductible or Out-of-Pocket Limit.

In the event of an Emergency, benefits for Prescription Drugs obtained from a Non-Designated Pharmacy will be paid as if they were purchased at a Designated Pharmacy.

A Designated Pharmacy will accept payment of the Prescription Deductible and/or Copay as full payment for Prescription Drugs if the Participant shows his identification card at the time of filling the prescription. The Prescription Deductible and/or Copay are shown in the Schedule of Benefits.

If the Participant does not show his identification card, or if he buys a Prescription Drug at a Non-Designated Pharmacy, he must pay the entire cost of the drug and file a claim for benefits. The claim must be submitted on a form approved by Us. Benefits may not be assigned to a Non-Designated Pharmacy, and any such attempted assignment shall be void.

If a Prescription Drug is purchased without use of the identification card during the first 30 days that a Participant is covered under this Prescription Drug Card Benefit, benefits will be paid for actual charges, up to the Reasonable Fee, reduced by the Prescription Deductible. The Participant must file a claim for benefits.

No more than a 30 day supply will be covered each time a prescription is filled or refilled at a Designated Pharmacy. Maintenance Drugs may be filled as follows:
1. 30 day supply at a Designated Pharmacy; or
2. up to 90 day supply through the mail order service program.

Limits on quantities and days supply may apply to certain therapeutic drug classes.

No more than a 30 day supply of Prescription Drugs, filled or refilled, will be covered within the 30 days immediately preceding the termination of this Plan. In the case of overpayment a refund will be requested from the Participant.

No more than a 30 day supply will be covered each time a prescription is filled or refilled when the prescription is for a Specialty Drug. Specialty Drugs are only available from a Designated Specialty Pharmacy.

If the Participant or the Participant's Physician specifically request a Brand Name Drug when a Generic Prescription Drug is available, the Participant will be responsible for the Generic Prescription Drug Copay plus the difference between the cost of the Brand Name Drug and the Generic Prescription Drug. This difference between the cost of the Brand Name Drug and the Generic Prescription Drug will not accumulate toward the Out-of-Pocket Limit. If it is Medically Necessary to receive a Brand Name Drug when a Generic Prescription Drug is available, the Participant or the Participant's Physician may submit an appeal. Refer to the Appeal Rights section of this Plan for detailed information on how to initiate the appeal process.

When the Out-of-Pocket Limit is reached, Prescription Drugs will be paid at 100%.

D. EXCLUSIONS AND LIMITATIONS

The Exclusions and Limitations section of the Comprehensive Medical Benefit apply. In addition, no benefits are paid, unless specified elsewhere in this Plan Document, for:
1. Drugs which do not meet the definition of Prescription Drugs;
2. Any drug containing nicotine for the purpose of use as a smoking deterrent, or other smoking deterrent medications, except as set forth in the Preventive Services section;
3. Anorectics (any drug used for the purpose of weight control);
4. Infertility medications unless coverage is specifically added to this Plan Document;
5. Non-legend drugs other than those specifically listed as covered;
6. Charges for the administration or injection of any drug;
7. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except as otherwise specified;
8. Prescriptions which a Participant is entitled to receive without charge under any Worker's Compensation Law;
9. Drugs labeled "Caution-limited by federal law to investigational use," or Experimental drugs, even though a charge is made to the Participant;
10. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order;
11. Medication which is to be taken by or administered to a Participant, in whole or part, while he is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
12. Immunization agents, biological sera, blood or blood plasma;
13. Charges that exceed the Reasonable Fee;
14. Any drug used to block the enzyme that stimulates hair growth or otherwise slows or retards hair growth, including Minoxidil (Rogaine) for the treatment of alopecia;
15. Imported Drugs;
16. Drugs, therapies and treatment for the restoration or enhancement of sexual activity;
17. Specialty Drugs not approved by or obtained through Our Designated Specialty Pharmacy;
18. Any Prescription Drug containing Bulk Chemical Powders; and

19. Charges for treatment, services, supplies or Prescription Drugs designed or used to diagnose, treat, alter, impact, or differentiate a Participant's genetic make-up or genetic predisposition, including but not limited to Genetic Therapy.

E. PRIOR AUTHORIZATION

Some Prescription Drugs require prior authorization to be covered. Prior authorization requires a drug's prescribed use to be evaluated against a predetermined set of criteria before the Prescription Drug will be covered. The pharmacist must contact the prescribing Physician to provide them with the phone number for the pharmacy benefit manager performing the prior authorization. The pharmacy benefit manager will determine the safety, efficacy, dosage and appropriateness of the Prescription Drug based on the information provided by the Physician. If the Prescription Drug does not meet the prior authorization criteria established by the pharmacy benefit manager, coverage will not be provided for that Prescription Drug.

If the authorization for the prescription is granted, the pharmacist will be notified of the approval.

If approval is not granted, the Participant can contact the Claim Processor to begin the appeal process.

Drugs which are not yet available or which have not yet been created may be excluded. Please call the phone number listed on the Identification Card to verify if such drug is covered.

TRANSPLANT BENEFIT

A. DEFINITIONS

Approved Transplant: A human organ or bone marrow transplant procedure currently performed at a Designated Transplant Facility.

Approved Transplant Services: Medically Necessary services and supplies which are related to an Approved Transplant procedure; are approved in writing under the Precertification process; and include but are not limited to:
1. pre-transplant patient evaluation for the Medical Necessity of the transplant;
2. Hospital charges;
3. Physician charges;
4. tissue typing and ancillary services; and
5. organ procurement or acquisition.

Designated Transplant Facility: A Facility which has a written agreement with a national organ transplant network that has an agreement with the Claim Processor to render Approved Transplant Services to Participants and their Dependents. This Facility may not be located in the Participant's geographic area.

Non-designated Transplant Facility: A facility which is not a Designated Transplant Facility.

Transplant Benefit Period: The period of time from the date the Participant receives Precertification and has an initial evaluation for the Approved Transplant Services until the earliest of:
1. one year from the date the Approved Transplant Services were performed;
2. the date coverage under the Comprehensive Medical Benefit Section terminates; or
3. the date of the Participant's or their Dependent's death.

If, during the same admission for the Approved Transplant Services, a retransplant occurs, the period of time is one year from the date of the Approved Transplant Services. If a retransplant will be done during a subsequent admission, a new Transplant Benefit Period starts from the date the Participant receives Precertification for the transplant.

B. DESIGNATED FACILITIES FOR APPROVED TRANSPLANT SERVICES

This section only applies to transplant procedures listed in the definition of Approved Transplant.

Approved Transplant Services require Precertification. The Participant or his Physician must call the toll free number provided to the Participant. Retransplantation procedures also require Precertification.

If it is determined that a transplant procedure is not Medically Necessary, the Participant will be informed, in writing of the right to a second opinion. A board certified specialist will be provided for this second opinion.

A Participant who will be receiving Approved Transplant Services will be referred to a Designated Transplant Facility. If the Participant is denied the procedure by the Designated Transplant Facility, he will be referred by Claim Processor's vendor to a second such Facility for evaluation. If the second Facility determines, for any reason, that the Participant is not an acceptable candidate for the procedure, no benefits will be paid for any

services or supplies related to that procedure, regardless of whether the services or supplies are provided at a third Designated Transplant Facility or at a Non-designated Transplant Facility.

C. BENEFITS

Benefits for Approved Transplant Services provided during a Transplant Benefit Period will be paid as shown in the Schedule of Benefits. Other transplant procedures will be considered for benefit payment according to the provisions of this Plan Document for any other surgical procedures.

Benefits will be paid for expenses incurred for Approved Transplant Services at a Designated Transplant Facility for:

1. organ procurement or acquisition;
2. reasonable and necessary lodging and meal expenses incurred near the Facility by the patient and by one companion accompanying him; and
3. air ambulance or other emergency transportation to, but not from, a Designated Transplant Facility, when necessary and approved, up to the limits shown in the Schedule of Benefits.

HIGH DOSE CHEMOTHERAPY FOLLOWED BY STEM CELL INFUSION OR AUTOLOGOUS OR ALLOGENIC BONE MARROW TRANSPLANT

High Dose Chemotherapy (HDC) followed by Stem Cell Infusion (SCI) will only be covered when Medically Necessary for neuroblastoma, acute leukemia in remission, resistant non-Hodgkin's lymphomas, advanced Hodgkin's disease, aplastic anemia, leukemia, hemoglobinopathies, metabolic storage disease, severe combined immunodeficiency disease (SCID), or treatment of Wiskott-Aldrich syndrome.

High Dose Chemotherapy followed by an Autologous Bone Marrow Transplant (ABMT) will only be covered when Medically Necessary for neuroblastoma, acute leukemia in remission, resistant non-Hodgkin's lymphomas, or advanced Hodgkin's disease.

High Dose Chemotherapy followed by an Allogenic Bone Marrow Transplant (ABMT) will only be covered when Medically Necessary for aplastic anemia, leukemia, hemoglobinopathies, metabolic storage disease, severe combined immunodeficiency disease (SCID), or treatment of Wiskott-Aldrich syndrome.

We will provide benefits for a Participant for covered HDC followed by SCI or ABMT.

The HDC/SCI/ABMT benefit period starts 5 days before the date the procedure is done and ends 12 months after the procedure is done. Only charges incurred during the HDC/SCI/ABMT benefit period will be considered for payment.

It is important to notify the Claim Processor before such procedure to make certain that it will be covered. The Physician must submit a complete medical history including current diagnosis. The Physician must certify that the procedure is Medically Necessary and that alternative procedures, services or courses of treatment would not be effective in the treatment of the patient's condition.

D. EXCLUSIONS

No benefits will be paid for any service:
1. related to the transplantation of any non-human organ or tissue;
2. for a facility or Physician outside the United States of America;
3. which are eligible to be repaid under any private or public research fund, whether or not such funding was applied for or received;
4. which results from complications of Approved Transplant Services unless such complications are determined by Claim Processor to be the immediate and direct result of Approved Transplant Services;
5. for High Dose Chemotherapy (HDC) followed by Stem Cell Infusion (SCI) or Autologous or Allogenic Bone Marrow Transplant (ABMT) except as described above; or
6. for transplants provided at a Non-designated Transplant Facility.

CONDITIONS OF COVERAGE

A. ELIGIBILITY

1. If You are an Eligible Employee at work on the date this Plan becomes effective You are eligible for coverage on that date.

2. If You are an initial enrollee or a new hire and You enroll for coverage during the initial Enrollment Period, coverage will become effective on the first day of the month following completion of the enrollment requirements.

3. Your Employer will determine Your eligibility class. If it changes after Your effective date You will become eligible under the new class on the first day of the calendar month coinciding with or next following the date of the change.

4. An Eligible Dependent who is in a class which provides coverage for Dependents will be eligible for coverage on the later of the following dates:
   a. the date You are eligible for coverage;
   b. the date he becomes an Eligible Dependent.

5. **Special Enrollee:** An Eligible Employee who declined enrollment for himself or his Eligible Dependents because of other health coverage, may be able to enroll himself or his Eligible Dependents in this Plan at a later date.

   a. The Participant will be eligible to enroll as a Special Enrollee if he/she previously declined coverage because:
      i. The Participant had other health coverage, which was terminated because he/she was no longer eligible due to death, legal separation, divorce, cessation of dependent status, a reduction in the numbers of hours of employment or termination of employment;
      ii. The Participant had other health coverage, which was terminated because the Participant's Employer stopped contributing to the plan;
      iii. The Participant had other health coverage for which he/she is no longer eligible or which was terminated because the lifetime limit was reached;
      iv. The Participant was covered under COBRA benefits, which have expired;
      v. The Participant had other health coverage which was terminated because he/she no longer resides, lives or works in the service area of the plan and no other benefit packages are available; or the Participant had other health coverage which was terminated because the plan no longer offers any benefits to the class of individuals with whom he/she is similarly situated.

   You and/or Your Eligible Dependent(s) referenced in 5.a.i. through 5.a.v. above must enroll within 31 days after termination or expiration of coverage.

   b. You and/or Your Eligible Dependents will be eligible to enroll as Special Enrollees upon the occurrence of one of the following events:
      i. marriage of the Eligible Employee;
      ii. the birth of his child or a child's adoption by an Eligible Employee; or
      iii. a child's placement for adoption with the Eligible Employee.

   You and/or Your Eligible Dependent(s) referenced in 5.b.i. through 5.b.iii. above must enroll within 31 days after the occurrence of the event.

   c. You and/or Your Eligible Dependents will be eligible to enroll as Special Enrollees upon the occurrence of one of the following events:
      i. loss of eligibility for coverage under a State Medicaid or Children's Health Insurance Program (CHIP); or
      ii. You or Your Eligible Dependent were determined to be eligible for state premium assistance under Medicaid or CHIP.

   You and/or Your Eligible Dependent(s) referenced in 5.c.i. and 5.c.ii. above must enroll within 60 days of being terminated from State Medicaid or CHIP coverage or being determined to be eligible for state premium assistance under Medicaid or CHIP, as applicable.

   An Eligible Employee or Eligible Dependent who does not enroll for coverage on the date they are first eligible to enroll must wait until the next Annual Open Enrollment Period unless they qualify as Special Enrollees.

B. EFFECTIVE DATE OF COVERAGE

1. The effective date of coverage is shown on the first page of this Plan Document.

2. Except as provided in 3. below, an Eligible Dependent's effective date will be the same as Your effective date unless You or Your Dependent are a Special Enrollee.

3. A child born to You while Your coverage is in force is automatically covered from the moment of birth if no additional contribution is required to cover such child. When additional contribution is required to cover the child You must submit an Employee Eligibility Statement with the newborn's information and pay the additional contribution amount required within 31 days after the date of birth in order for coverage to become effective. If You fail to submit the Employee Eligibility Statement within 31 days after the date of

birth, or You reject Dependent coverage and later want to cover Dependents, You must wait until the next Annual Open Enrollment Period to add Your Eligible Dependent.

4. If You or Your Dependent applies for coverage as a Special Enrollee during the first 31 days after the date You are eligible, Your effective date shall be the first day of the month coinciding with or next following the date You apply.

C. TERMINATION OF COVERAGE

1. Your coverage under this Plan will end:
   a. if You do not pay, when due, any required contribution;
   b. if You ask to end Your coverage;
   c. when You become a member of any military, naval or air force on active duty;
   d. when any continuation of coverage ends, if You do not return to work for Your Employer;
   e. when this Plan terminates;
   f. on the last day of the month in which Your work terminates;
   g. at the end of a 6-month period in which You are not actively at work due to Disability.

2. A Dependent's coverage under this Plan will end:
   a. If You do not pay, when due, any required contribution for the Dependent's coverage.
   b. If You ask to end his coverage;
   c. when the Dependent becomes a member of any military, naval or air force on active duty;
   d. when Your coverage terminates;
   e. when his status as a Dependent ends;
   f. when Dependent's coverage terminates for his class;
   g. on the last day of the month in which a Dependent child reaches 26 years of age;
   h. when this Plan terminates.

D. RESUMPTION OF COVERAGE

Coverage which ends due to leave of absence or layoff of not more than 6 months may be resumed on the first day of the month following the date You return to full-time work, if You are otherwise eligible and Your contribution is paid. If You return to work after leave of absence or layoff of more than 6 months You must apply in writing for coverage and complete the required length of service as if You were a new employee.

CLAIM PAYMENT PROVISIONS

A. CLAIM PAYMENT

1. PROOF OF LOSS

   Written proof must be given within 15 months after the date charges are incurred. Charges are considered incurred on the date a service is rendered or a supply is furnished. We will pay benefits upon receipt of proof of loss. All proof of loss must be satisfactory to Claim Processor. The proof of loss must describe the event, the nature and the extent of the cause for which a claim is made.

2. BALANCE BILL AMOUNTS

   Notice of a Balance Bill Amount must be given as soon as possible, but in no event later than 15 months following the end of the Plan Year. Notice of a Balance Bill Amount must be provided to Claim Processor at the telephone number listed on the explanation of benefits (EOB) for which the Balance Bill Amount applies. Claims Processor's vendor will negotiate reimbursement of Balance Bill Amount with provider when such amount is in excess of the maximum dollar amount agreed upon between the Claim Processor, Claims Processor's vendor and Plan Sponsor. When the Balance Bill Amount does not exceed the maximum dollar amount agreed upon between the Claim Processor, Claims Processor's vendor and Plan Sponsor, this Plan will reimburse Balance Bill Amounts in excess of the Reasonable Fee. If the Negotiated Amount is not paid prior to the end of the 15 month period following the end of the Plan Year, no payment by the Plan will be made for such Amount.

3. TIME OF PAYMENT OF CLAIMS

   Claims for benefits will be considered in the order that written proof of loss is received. The order that proof of loss is received may not be the same as the order in which claims were incurred.

4. PAYMENT OF CLAIMS

   Payment may be made directly to the Facility or provider furnishing a covered service. In the case where a Dependent child is in the custody of a person other than the Participant, payment will be made to the

custodian of the child, at Our discretion or as required by law. Any benefits unpaid at death will be paid either to Your estate or under the "Facility of Payment" provision. Other benefits will be paid to You.

5. BENEFITS PAYABLE

   Total benefits paid will never exceed actual expense incurred.

6. UNBUNDLING AND MULTIPLE PROCEDURE BILLING PRACTICES

   When certain complicated medical and dental procedures are performed, other less extensive procedures may be performed at the same time, as component parts of the primary procedure. For benefit purposes, these less extensive procedures are considered to be integral components of the primary procedure. Even if the provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

   In cases where separate benefits are warranted when more than one surgical procedure is performed on the same day and at the same operative session, the total benefit payable for such surgical procedures will be 100% of the Covered Charge for the primary procedure and 50% of the Covered Charge for the second through fifth procedures. All remaining procedures will be covered at no less than 25% of the Covered Charge.

7. ASSIGNMENT

   This Plan will pay benefits hereunder to the Eligible Employee unless payment has been assigned to a Hospital, Physician or other provider of service furnishing the services for which benefits are provided herein. No Assignment of Benefits shall be binding on this Plan unless the Claim Processor is notified in writing of such assignment prior to payment hereunder.

   This Plan will pay benefits to the responsible party of an alternate recipient as designated in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

8. BENEFITS NOT TRANSFERABLE

   Except as otherwise stated herein, no person other than a Participant is entitled to receive benefits under this Plan. Such right to benefits is not transferrable.

9. LOST DISTRIBUTEES

   Any benefit payable hereunder shall be deemed forfeited if the Claim Processor is unable to locate the Participant to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the Participant for the forfeited benefits within the time prescribed above.

B. FACILITY OF PAYMENT

If benefits are payable to Your estate, up to $1000.00 of benefits may be paid to someone related to You by blood or marriage who is considered to be entitled to the benefits. If You are physically, mentally, or otherwise incapable of giving a valid release for any payment, up to $1000.00 of benefits may be paid to someone related to You by blood or marriage, or to any person or institution which has assumed financial responsibility for Your affairs.

GENERAL PROVISIONS

A. FRAUDULENT OR INTENTIONAL MISREPRESENTATIONS

A Participant's coverage may be rescinded or terminated, and claims may be denied for fraud or intentional misrepresentations of material fact when completing the Employee Eligibility Statement, or similar accepted form, with false, incomplete or misleading information. Thirty days advance written notice will be provided to the Participant prior to any rescission of coverage.

B. PHYSICAL EXAMINATIONS AND AUTOPSY

Claim Processor has the right, at Claim Processor's own expense, to have a Participant examined as often as reasonably necessary while a claim on the Participant is pending and to have an autopsy made where allowed by law.

C. LEGAL ACTION

The decision by the Claim Processor/Plan Sponsor/Plan Administrator on review will be final, binding, and

conclusive, and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal or equitable action is brought. Notwithstanding any other state or federal law, any and all legal actions to recover benefits, whether against the Plan, the Plan Sponsor/Plan Administrator, the Claim Processor, any other fiduciary, or their employees, must be filed within one year from the date all claim review procedures provided for in this Plan Document have been exhausted.

D. ADMINISTRATION OF THIS PLAN

This Plan may be amended or terminated at any time or as required by law at any time without Your consent or notice to You. Amendment of the Plan will not affect a claim starting before the effective date of the amendment. The Claim Processor is a named fiduciary for purposes of making decisions of whether a claim for benefits is payable under the terms of this Plan. As named fiduciary, the Claim Processor maintains discretionary authority to review whether a claim for benefits is payable under the terms is this Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

E. REIMBURSEMENT

You shall, on behalf of Yourself and Your Dependents, if any, reimburse Us for benefits provided or paid for, for which a person was not eligible under the terms of this Plan. You must pay Us back as soon as We notify You and request the reimbursement. At Our option, We may reduce or refuse payment for subsequent requests for benefits as a set-off toward such reimbursement. The acceptance of contribution amount or other fees or the providing or paying of benefits by Us shall not constitute a waiver of Our rights to enforce these provisions in the future. This provision shall be in addition to, and not in lieu of, any other remedy available to Us at law or in equity.

F. APPLICABLE LAW

All provisions of this Plan shall be construed and administered in a manner consistent with the requirements under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

G. CONFORMITY WITH STATUTE(S)

Any provision of this Plan which is in conflict with statutes which are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).

H. FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any Participant entitled to benefits hereunder to select a Hospital or to make a free choice of the attending Physician or provider. However, benefits will only be provided for transplants performed at a Designated Transplant Facility and for Specialty Drugs purchased from a Designated Specialty Pharmacy.

I. LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the Employer shall not be liable for any obligation of the Participant incurred in excess thereof. The Employer shall not be liable for the negligence, wrongful act, or omission of any Physician, provider, Hospital, or other institution, or their employees, or any other person. The liability of this Plan shall be limited to the reasonable cost of Covered Charges and shall not include any liability for suffering or general damages.

J. PLAN IS NOT A CONTRACT

This Plan shall not be deemed to constitute a contract between the Employer and any employee or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in this Plan shall be deemed to give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to terminate the employment of any employee at any time.

K. WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

COORDINATION OF BENEFITS

This provision applies to the Comprehensive Medical Benefit, and Prescription Drug Card Benefit.

Coordination of Benefits applies when a person has health care coverage under more than one Plan. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the primary Plan. The primary Plan must pay benefits in accordance with its terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the primary Plan is the secondary Plan. The secondary Plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable Expense.

A. DEFINITIONS

Coordination of Benefits: Means taking other Plans into account when paying benefits. Coordination of Benefits will apply to Comprehensive Medical and Prescription Drug Card Benefits.

Plan: A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no Coordination of Benefits among those separate contracts.

Plan includes: Group and nongroup insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plans, as permitted by law.

Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each of the coverages described above is a separate Plan. If a Plan has two parts and Coordination of Benefits rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means, in a Coordination of Benefits provision, the part of the Plan Document providing the health care benefits to which the Coordination of Benefits provision applies and which may be reduced because of the benefits of other Plans.

Allowable Expense: A necessary, usual and customary expense incurred due to Sickness or Injury which the Participant is required to pay. A part of the expense must be covered under at least one Plan. When a Plan provides benefits by services, the cash value of each service will be treated as both an Allowable Expense and a benefit paid.

A benefit reduction under a primary Plan for noncompliance with Plan provisions will not be considered an Allowable Expense. Such Plan provisions include: second surgical opinions; precertification; preferred provider arrangements and similar provisions.

As the secondary Plan, We will not refuse to pay benefits when an HMO member elects to use the services of a non-HMO provider and, pursuant to contract, the HMO is not obligated to cover such services.

Closed Panel Plan: A Plan that provides health care benefits to Participants primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent: The parent awarded custody by a court decree or, in the absence or a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

B. WHEN COORDINATION OF BENEFITS APPLIES

Coordination of Benefits will apply when benefits that would be paid under all Plans exceed the Allowable Expense.

When this Plan is secondary, as determined by these provisions, claims will not be considered for payment until the primary payer meets all contractual liabilities under the primary Plan notwithstanding any coordination of benefits provision in the primary Plan limiting liability to a particular dollar amount, and notwithstanding any provision in the primary Plan claiming permanent secondary payer status.

C. LIMITATION OF BENEFITS UNDER COORDINATION

When Coordination of Benefits applies, benefits payable under this Plan may be reduced. They will be reduced so that the sum of the benefits paid under this Plan, plus benefits payable under all other plans, does not

exceed the total Allowable Expense. Benefits payable under other Plans include benefits that would be paid if a claim had been made.

D. RULES FOR PAYMENT WHEN TWO OR MORE PLANS CONTAIN A COORDINATION OF BENEFITS PROVISION

The rules for the order of benefit payment are summarized below. When this Plan must pay first, coordination will not apply. The primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

1. **Non-dependent/Dependent.** A Plan which covers a person other than as a Dependent will pay before a Plan which covers that person as a Dependent. If, however, the person is also a Medicare beneficiary, Medicare is:
   i. secondary to the Plan covering the person as a Dependent; and
   ii. primary to the Plan covering the person as other than a Dependent.

2. **Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

   i. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
      1. The Plan of the parent whose birthday falls earlier in the calendar is the primary Plan;
      2. If both parents have the same birthday, the Plan which has covered a parent for the longer period is the primary Plan.

   ii. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      1. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan Years commencing after the Plan is given notice of the court decree;
      2. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 2.i. above shall determine the order of benefits;
      3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 2.i. above shall determine the order of benefits;
      4. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         a. The Plan covering the Custodial Parent;
         b. The Plan covering the spouse of the Custodial Parent;
         c. The Plan covering the non-Custodial Parent, and then;
         d. The Plan covering the spouse of the non-Custodial Parent.

3. **Active/Inactive.** A Plan which covers a person as an active employee is the primary Plan. The Plan covering the same person as a laid off or retired employee or as his Dependent will pay after a Plan covering the person as an active employee or his dependent. If the other Plan does not have this provision and, as a result, each Plan determines its benefits after the other, then this provision will not apply.

4. **Continuation**. A Plan covering a person as an employee or dependent shall be Primary to a Plan covering that person under state or federal continuation. This subsection shall not apply if the other Plan does not contain an order of benefits determination and the Plans do not agree on the order.

5. When these rules do not establish an order of payment, the Plan which has covered the person for the longer period of time will pay first.

6. If none of these rules determine the order of benefits, the Allowable Expense will be shared equally between the Plans meeting the definition of Plan. This Plan will not pay more than it would have paid had it been the primary Plan.

E. COORDINATED BENEFITS NOT CHARGED TO BENEFIT LIMIT

If benefits paid under this Plan are reduced because of coordination, each benefit will be reduced proportionately. Only the amount actually paid will be charged against any benefit limit.

F. BENEFIT CREDIT DUE TO COORDINATION OF BENEFITS

If benefits under this Plan are reduced because of coordination, the amount of the reduction will be a benefit credit for the same claim. The credit may be used to pay that portion of Allowable Expense which would otherwise not be paid by any Plan.

The credit may only be used to pay that portion of a charge which is incurred during the same Plan Year as the credit. Total benefits paid will not exceed the total payable in the absence of coordination.

G. RIGHT TO EXCHANGE INFORMATION

We may release to, or obtain from, any other insurance company or organization or person information necessary for Coordination of Benefits without consent, or notice to the Participant. You are required to provide any information necessary for Coordination of Benefits.

H. RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN

Coordination may result in another Plan making payments which should be made by this Plan. We will then pay the other Plan all amounts which would otherwise have been paid directly to You.

I. RIGHT TO RECEIVE PAYMENTS

If coordination results in overpayments by Us, We have the right to recover the excess amounts paid.

MEDICARE

These provisions apply to Comprehensive Medical Benefits.

A. This subsection applies to: (1) Eligible Employees who are at least 65 years of age; and (2) the spouse of an Eligible Employee when the spouse is at least 65 Years of age.

   1. Benefits will be paid secondary to Medicare when Employer has less than 20 employees. Covered Charges will be reduced by any benefits payable by Medicare.
   2. When Employer has 20 or more employees and is subject to the Social Security Act (Section 1862 (b)), Comprehensive Medical Benefits will be paid primary to Medicare. You or Your spouse may choose to voluntarily waive coverage under this Plan and elect Medicare as sole payor.

B. If Employer has 100 or more employees, Medicare pays secondary for any Participant who is entitled to Medicare on the basis of Disability, and the Eligible Employee maintains employee status.

C. Benefits will be paid primary to Medicare if You or Your Dependent are entitled to Social Security benefits solely on the basis of end stage renal disease, but only during a period of up to 30 consecutive months. The 30-month period begins with the earlier of:

   1. the month in which a regular course of renal dialysis is initiated; or
   2. in the case of a Participant who receives a kidney transplant, the first month in which the Participant becomes entitled to Medicare.

   After 30 months, benefits will be paid secondary to Medicare.

Except with respect to C. as provided above, notwithstanding anything in this Plan to the contrary, if the Participant fails to enroll in Medicare parts A and B upon being eligible for Medicare, benefits will be paid as if Medicare paid primary.

CONTINUATION OF COVERAGE PROVISIONS

A. CONTINUATION OF COVERAGE FOR ELIGIBLE EMPLOYEES AND DEPENDENTS UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

This provision applies if Employer is subject to COBRA and if You are covered under this Plan. When this continuation applies, no other continuation of coverage applies.

Employer is responsible for providing You and Your Dependents with notice of the rights and obligations under COBRA.

Qualifying Events: You or Your Dependents may elect to continue Medical Benefits which would otherwise end because:
1. Your employment terminates for reasons other than gross misconduct; or
2. Your hours of employment are reduced, and You are no longer eligible for coverage. Coverage does not include coverage provided under other continuation; or

Your Dependents may elect to continue Medical Benefits which would otherwise end because:
1. You die;
2. You become entitled to Medicare;
3. You and Your spouse divorce or legally separate; or
4. a child ceases to be a Dependent as defined.

Notice: You or Your Dependents must notify the Employer within 60 days of the loss of Dependents status, dissolution of marriage or legal separation in order to be eligible for COBRA continuation.

Election: If eligible for COBRA continuation, You and/or Your Dependents will have a 60-day period in which to make the election to continue. This period is measured from the later of:
1. the date coverage would end; or
2. the date the COBRA election form is sent to You.

Employer is responsible for providing You with a COBRA election form. The election form will set forth the requirements for electing COBRA continuation. The first payment must be made within 45 days of the election date. This continuation option ends and coverage terminates if You or Your Dependent fails to:
1. elect continuation within the specified time period; or
2. pay the initial amount when due.

Duration of Coverage: COBRA continuation ends on the earliest of the following:
1. the end of the maximum period of entitlement, which is:
   a. 18 months for continuation due to Your loss of employment or reduction in work hours; or
   b. 36 months for continuation due to any other qualifying event. When the qualifying event is loss of employment or reduction in work hours, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation for Your Dependents lasts until the later of: 36 months after the date of Your Medicare entitlement; or 18 months (29 months in the event of a Disability extension) after the date of Your loss of employment or reduction in hours.
   c. 36 months for continuation for Dependents if the qualifying event is Your loss of employment or reduction in work hours and Your Dependent experiences a second qualifying event while receiving COBRA continuation coverage. Medicare entitlement is not a second qualifying event unless You would lose coverage as a result of such entitlement. In all instances, the maximum period for continuation remains 18 months. The Employer must be notified of the second qualifying event within 60 days of the second qualifying event.
2. the end of the period for which the payment is made;
3. the date the Plan terminates;
4. following a qualifying event, the date on which You or Your Dependents first become covered under another group health plan; or
5. as to any Participant the date the person first becomes, after his qualifying event, entitled to Medicare.

The coverage period for COBRA continuation is measured solely from the date of the earliest qualifying event.

The 18-month continuation period may be extended to 29 months if prior to the end of the 18 months:
1. the Participant is determined to have been Disabled for Social Security purposes within 60 days after termination of employment or reduction in hours; and
2. the Participant notifies the Employer of such determination within 60 days of the determination.

For a Participant whose COBRA continuation has been continued beyond 18 months due to Disability which occurs during the first 60 days of COBRA continuation, coverage ends on the first of the month that is more than 30 days after a final determination by Social Security that such Participant is no longer Disabled.

The Participant must also notify the Employer within 30 days of a determination that he is no longer Disabled.

Payment: Payment for coverage is the responsibility of the Participant electing COBRA continuation. You may be charged an additional administration fee of 2% of the current payment. The payment for a Participant entitled to Social Security Disability Benefits may be 150% (including the 2% administration fee) of the current amount for the 19th through 29th month of continued coverage.

COBRA continuation will not be provided if:
1. You or Your Dependents do not notify the Employer within 60 days of a qualifying event that is divorce, legal separation, a child ceasing to qualify as a Dependent as defined, or within 60 days of a determination of Disability by the Social Security Administration.
2. You or Your Dependents do not elect COBRA within the 60 day election period.
3. the Employer does not notify the COBRA Administrator within 60 days of the election date.

B. CONTINUATION DURING ACTIVE MILITARY DUTY

If You are called for active duty by the United States Armed Services, You and Your Dependents may continue Your health coverage pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

After the first 31 days of Your active military duty, the Employer may charge You up to 102% of the full contribution amount.

The maximum length of the continuation coverage under USERRA is the lesser of:
1. 24 months beginning on the day that the military leave for active duty commences, or
2. The period beginning on the day after the date on which You fail to return to employment within the time allowed under USERRA.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA or any other continuation provision in this Plan.

Upon return to employment following active duty, You and Your Dependents will be reinstated under the Plan without a waiting period except as permitted under USERRA.

SUBROGATION/RIGHT OF REIMBURSEMENT

This Plan is designed to only pay Covered Charges for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a Participant in a time of need, however, this Plan may pay Covered Charges that may be or become the responsibility of another person, provided that this Plan later receives reimbursement for those payments (hereinafter called “Reimbursable Payments”).

Therefore, by enrolling in this Plan, as well as by applying for payment of Covered Charges, a Participant is subject to, and agrees to, the following terms and conditions with respect to the amount of Covered Charges paid by this Plan:

1. Assignment of Rights (Subrogation). The Participant automatically assigns to this Plan any rights the Participant may have to recover all or part of the same Covered Charges from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by this Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a Participant or paid to another for the benefit of the Participant. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the Participant constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows this Plan to pursue any claim that the Participant may have, whether or not the Participant chooses to pursue that claim. By this assignment, this Plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. This Plan shall have an equitable lien against any rights the Participant may have to recover the same Covered Charges from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by this Plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where this Plan has paid Covered Charges prior to a determination that the Covered Charges arose out of and in the course of employment. Payment by workers' compensation insurers or the Employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the Participant, the Participant's attorney, and/or a trust) as a result of an exercise of the Participant's right of recovery (sometimes referred to as “proceeds”). This Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Plan Sponsor, this Plan may reduce any future Covered Charges otherwise available to the Participant under this Plan by an amount up to the total amount of Reimbursable Payments made by this Plan that is subject to the equitable lien.

   This and any other provisions of this Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of this Plan concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the “make whole” rule and the “common fund” rule.

3. Assisting in Plan's Reimbursement Activities. The Participant has an obligation to assist this Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the Participant, and to provide this Plan with any information concerning the Participant's other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the Participant. The Participant is required to (a) cooperate fully in this Plan's (or any Plan fiduciary's) enforcement of the terms of this Plan, including the exercise of this Plan's right to subrogation and reimbursement, whether against the Participant or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including this Plan as a co-payee for the amount of the Reimbursable Payments and notifying this Plan), (c) sign any document deemed by the Plan Sponsor to be relevant to protecting this Plan's subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term “information” includes any documents, insurance policies, police reports, or any reasonable request by the Plan Sponsor or claims administrator to enforce this Plan's rights.

The Plan Sponsor has delegated to the Claim Processor for medical claims the right to perform ministerial functions required to assert this Plan's rights with regard to such claims and benefits.

HIPAA PRIVACY

The following provisions are intended to comply with applicable Plan amendment requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DISCLOSURE BY PLAN TO PLAN SPONSOR

The Plan may take the following actions only upon receipt of a Plan amendment certification:

1. Disclose protected health information to the Plan Sponsor.
2. Provide for or permit the disclosure of protected health information to the Plan Sponsor by a health insurance issuer or HMO with respect to this Plan.

USE AND DISCLOSURE BY PLAN SPONSOR

The Plan Sponsor may use or disclose protected health information received from the Plan to the extent not inconsistent with the provisions of this HIPAA Privacy section or the privacy rule.

OBLIGATIONS OF PLAN SPONSOR

The Plan Sponsor shall have the following obligations:

1. Ensure that:
   a. Any agents (including a subcontractor) to whom it provides protected health information received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; and
   b. Adequate separation between this Plan and the Plan Sponsor is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(iii).
2. Not use or further disclose protected health information received from this Plan, other than as permitted or required by the Plan documents or as required by law.
3. Not use or disclose protected health information received from this Plan:
   a. For employment-related actions and decisions; or
   b. In connection with any other benefit or employee benefit plan of the Plan Sponsor.
4. Report to this Plan any use or disclosure of the protected health information received from this Plan that is inconsistent with the use or disclosure provided for of which it becomes aware.
5. Make available protected health information received from this Plan, and as to the extent required by the privacy rule:
   a. For access to the individual;
   b. For amendment and incorporate any amendments to protected health information received from this Plan; and
   c. To provide an accounting of disclosures.
6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from this Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by this Plan with the privacy rule.
7. Return or destroy all protected health information received from this Plan that the Plan Sponsor still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by this Plan was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
8. Provide protected health information only to those individuals, under the control of the Plan Sponsor who perform administrative functions for this Plan; (i.e., eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for Plan administrative functions nor to release protected health information to an unauthorized individual.
9. Provide protected health information only to those entities required to receive the information in order to maintain this Plan (i.e., claim administrator, case management vendor, pharmacy benefit manager, claim subrogation, vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering this Plan).
10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.
11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of this Plan. Specifically, such safeguarding entails an obligation to:
    a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the Plan Sponsor creates, receives, maintains, or transmits on behalf of this Plan;
    b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
    c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

d. Report to this Plan any security incident of which it becomes aware.

EXCEPTIONS

Notwithstanding any other provision of this HIPAA Privacy section, this Plan (or a health insurance issuer or HMO with respect to this Plan) may:

1. Disclose summary health information to the Plan Sponsor if the Plan Sponsor requests it for the purpose of:
   a. Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
   b. Modifying, amending, or terminating this Plan;
2. Disclose to the Plan Sponsor information on whether the individual is participating in this Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by this Plan;
3. Use or disclose protected health information:
   a. With (and consistent with) a valid authorization obtained in accordance with the privacy rule;
   b. To carry out treatment, payment, or health care operations in accordance with the privacy rule; or
   c. As otherwise permitted or required by the privacy rule.

CLAIM REVIEW AND APPEALS

Claim Review and Appeal Rights under Federal Law

Definitions:

- **Adverse Benefit Determination** – any denial (in whole or in part) of a Pre-service Claim, Concurrent Care Claim or Post-service Claim, or any rescission of coverage.

- **Pre-service Claim** – a claim for medical services that have not yet been rendered and require pre-authorization and/or pre-certification. There are two (2) categories of Pre-service Claims:
  - Urgent Pre-service Claim – any Pre-service Claim for medical care that, if treated as a Non-Urgent Pre-service Claim, could seriously jeopardize the life or health of the claimant, or the ability of the claimant to regain maximum function, or would subject the claimant to severe pain.
  - Non-Urgent Pre-service Claim – a Pre-service Claim that is neither an Urgent Pre-Service Claim nor a Concurrent Care Claim.

- **Concurrent Care Claim** – a claim for a previously approved, ongoing course of medical treatment. There are two (2) categories of Concurrent Care Claims:

  - Urgent Concurrent Care Claim – a claim for ongoing medical care that, if treated as a Non-Urgent Concurrent Care Claim, could seriously jeopardize the life or health of the claimant, or the ability of the claimant to regain maximum function, or would subject the claimant to severe pain.
  - Non-Urgent Concurrent Care Claim – a claim for ongoing medical care that is not an Urgent Concurrent Care Claim.

- **Post-service Claim** – a claim for medical services that have already been rendered that is not a Concurrent Care Claim**.**

- **Named Fiduciary for Health Benefit Plan Claims:** Claim Processor is a named fiduciary for purposes of making decisions of whether a claim for benefits is payable under the terms of this Plan.

Timing of Claim Determinations for Pre-service Claims and Concurrent Care Claims.

- Pre-service Claims:
  - Urgent Pre-service Claim – Notification will be provided within 72 hours after receipt, unless additional information is necessary. Notification will be provided within 24 hours if additional information is needed, and the Participant will have 48 hours to submit the information. A determination will be made within 48 hours after receipt of the additional information. If the requested information is not received, a determination will be made based upon the information available.
  - Non-Urgent Pre-service Claim – Notification will be provided within 15 days after receipt, unless additional information is requested. Notification will be provided within 5 days if additional information is needed, and the Participant will be given 45 days to submit the additional information. A determination will be made within 15 days of the receipt of the additional information. If the requested information is not received, a determination will be made based upon the information available.

- Concurrent Claims:
  - Notification of an Adverse Benefit Determination regarding a previously approved ongoing course of treatment will be sent sufficiently in advance to allow the Participant to appeal the adverse determination. If, at least 24 hours before the end of a course of previously approved ongoing treatment, an extension for that treatment is requested, then a determination will be made within 24 hours of receipt of the request.
  - If the request is received less than 24 hours before the end of the course of treatment, the Urgent Pre-service Claim procedures described above will be followed.

Timing for Claim Determinations for Post-service Claims:
A Post-service Claim is considered to be filed under this Plan when the following information is received by the Claim Processor with a Form CMS-1500 or Form UB92 or any successor forms:

- The date of service;
- The name, address, and tax identification number of the healthcare provider;
- The place where the service was rendered;
- The diagnosis and procedure codes;
- The amount charged for each service;
- The name of the Employer, Employee, and patient;
- An itemized statement of charges and descriptions of the services, unless the Claim Processor determines, in its sole discretion, that such itemized statements and descriptions are not needed, or that any portion of such itemized statements and descriptions that have been submitted are sufficient.

Notice of benefit determination will be provided within:

- 30 days of receipt of a Post-service Medical claim.

If a determination cannot be made within that timeframe due to circumstances beyond Claim Processor's control, notification will be sent within the 30 day timeframe that more time is needed to determine benefits. However, Claim Processor may not take more than 45 days to determine benefits.

If all necessary information is not submitted, notification of any additional information needed for a benefit determination will be sent. The Participant will have 45 days from receipt of Claim Processor's request to submit the information. The time period during which Claim Processor is waiting for receipt of the necessary information does not count toward the timeframe in which Claim Processor must make a benefit determination. If the requested information is not provided within the 45 day period, the claim will be denied. The Participant may submit such claim for reconsideration, with the requested information, within the timeframe specified below under Appeal Rights.

Content of Notice of Adverse Benefit Determination:
Any notice of Adverse Benefit Determination on a Pre-service, Concurrent Care or Post-service Claim will include:

- Information sufficient to identify the claim involved.
- The specific reasons for any adverse determination, and reference to the specific Plan provision(s) on which determination is based.
- A description of any additional information needed.
- A description of this Plan's appeal procedures and applicable time limits.
- The contact information for Claim Processor's office and other agencies and offices available to assist with the appeals process and any additional information required by law.

In addition, if the Adverse Benefit Determination was rendered on a claim for medical benefits, the notice of Adverse Determination will include a statement that any internal rule, guideline, protocol or other similar criteria used in the determination will be provided upon request at no charge. If the adverse determination on a medical claim was based on medical judgment, the notice of Adverse Benefit Determination will include a statement that an explanation of medical judgment will be provided upon written request at no charge.

If a Pre-service, Concurrent or Post-service Claim is denied or partly denied as an Adverse Benefit Determination, the Participant shall have a reasonable opportunity for an appeal and a right to a full and fair review. Please refer to the Appeal Rights provision below.

Appeal Rights

Opportunity to Request an Appeal -
The Participant has the right to appeal an Adverse Benefit Determination rendered on a Pre-service, Concurrent Care or Post-service Claim. Appeal of an Urgent Pre-service Claim or an Urgent Concurrent Care Claim may be requested verbally; all other appeal requests must be in writing. The Participant's appeal rights will be forfeited if an appeal to Claim Processor is not submitted, at the address identified below, within 180 days from receipt of the claim decision.

Claim Processor will provide the Participant with a full and fair review of the claim appeal. The Participant has the right to review the claim file and to present evidence and testimony as part of the claim appeal. If the Participant is dissatisfied with a first level appeal review, the Participant will have the right to request a second level appeal review. The second level appeal request must be submitted to Claim Processor in writing within 60 days from receipt of the first level appeal decision. All appeals will be reviewed by someone with the appropriate expertise and who was not involved with the original decision.

If Claim Processor upholds a claim decision on the second level of appeal, Claim Processor will provide any new or additional evidence or rationale that was considered, relied upon, or generated by Claim Processor in connection with the claim review in advance of the date on which the notice of a final internal benefit determination is provided. If it is impossible to provide the new or additional evidence or rationale in time for the Participant to have a reasonable opportunity to respond, the timing for appeal determinations as outlined below will be tolled until the earliest of:

1. The date the Participant responds to the new or additional evidence or rationale; or
2. Three weeks from the date the new or additional evidence or rationale was sent via U.S. mail; or
3. Ten calendar days from the date the new or additional evidence or rationale was sent electronically.

The written appeal should include the Participant's name and identification number from the identification card, the basis for the appeal and any supporting documentation. If the appeal relates to a claim payment decision, the written appeal should also include the date(s) of medical service(s) and the applicable health care

provider's name.

Faxed or written appeals must be sent to:

Star Marketing and Administration, Inc.
Grievance Review – Dept. 1146
400 Field Drive
Lake Forest, IL 60045
Fax (330) 965-7599

Timing for Appeal Determinations:
Once a request for an appeal is received, a determination will be made no later than:

- Pre-service and Concurrent Care Claims involving Urgent Care: 72 hours from Claim Processor's receipt of the appeal. Depending on the nature of the review, the Participant may have the right to request an expedited external review. Please refer to the Expedited External Review provision below.
- Pre-service and Concurrent Care Claims involving Non-Urgent Care: 15 days from Claim Processor's receipt of the appeal.
- Post-service Claims: 30 days from Claim Processor's receipt of the appeal.

If the Participant fails to submit the written appeal to the correct address or fax number, Claim Processor reserves the right to deny the request and will provide notice of such denial. Claim Processor may also choose to process the request, however the timeframe for processing the appeal will not begin to run until the correspondence is received by the Grievance Review area of Claim Processor's office.

Once the Participant has exhausted both the first and second level appeals, notice will be provided of the right to request an external review by an independent review organization.

EXTERNAL APPEAL

The notice of a final internal Adverse Benefit Determination will include detailed information about the Participant's right to request an external review and the process for making such request. With respect to the external review process, an Adverse Benefit Determination shall only include those determinations that involve: 1) medical judgment, including, but not limited to medical necessity, appropriateness, Experimental/Investigational, health care setting, level of care, or effectiveness of a covered benefit; 2) whether items or services are subject to the requirements described in the Nonpreferred Provider section of this Plan; and 3) rescissions of coverage.

The Participant or the Participant's authorized representative will have four (4) months from receipt of notification of the final internal Adverse Benefit Determination to request an external review.

RIGHT TO EXTERNAL APPEAL

Within five (5) days of receipt of the request for an external review (or immediately in the case of a request for an expedited external review), Claim Processor will make a preliminary determination if the claim is eligible for external review, based on confirmation that:

1. The Participant is covered under the Plan at the time the health care item or service is requested or, in the case of a retrospective review, was covered under the Plan at the time health care item or service was provided;
2. External review is available based on the reason for the Adverse Benefit Determination;
3. The Participant has exhausted the Plan's internal appeal process;
4. The Participant has provided all of the necessary information and forms required to complete an external review.

Within one business day of the preliminary review determination (or immediately in the case of a request for an expedited external review), Claim Processor will send written notice as to whether the request has been accepted. If the Participant is not eligible for external review, the written notice will explain the reason for the ineligibility and provide contact information for the Employee Benefits Security Administration. If the request for external review is not complete, the written notice will describe the information or materials needed and will give the Participant until the end of the 4 month period or 48 hours, whichever is later, to provide such information or materials.

INDEPENDENT REVIEW ORGANIZATION

The Plan will assign an Independent Review Organization (IRO) that is accredited by URAC or other nationally

recognized accrediting organization to conduct the external review using a process to guard against bias and ensure independence in review determinations. Once an IRO accepts the request for external review, the IRO will have 45 days to provide written notice of its decision.

If the IRO reverses Claim Processor's decision, We will have the claim paid or otherwise provide coverage consistent with the IRO's determination. The IRO's decision is binding on the Participant and Us and the Claim Processor except to the extent that other remedies may be available under State or Federal law.

EXPEDITED EXTERNAL REVIEW

The Participant may request an expedited external review at any time following receipt of an Adverse Claim Determination (even if the Participant has not exhausted the internal appeal process) if such determination involves a medical condition for which the timeframe to complete an internal appeal or the timeframe to complete a standard external review seriously jeopardize the Participant's life, health, or ability to regain maximum function. In the event of an expedited external review, the external review will be conducted on an expedited basis and a decision will be rendered by the IRO and communicated within 72 hours after the IRO receives the request.

AERIE CORPORATION
Privacy Officer
804 PENDLETON ST
GREENVILLE, SC 29601

NOTICE OF PRIVACY PRACTICES
Effective date of this notice: July 1, 2022

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer this plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.