Plan Document
and
Summary Plan Description

The City of Savannah
Employee Group Medical Plan - TCN

Group No: 001WF8

Effective: January 1, 2022

THE CITY OF SAVANNAH
EMPLOYEE GROUP
MEDICAL BENEFIT PLAN(S)
SUMMARY OF MATERIAL MODIFICATIONS

The Medical Benefit Plan(s) offered by The City of Savannah and administered by Health Plans, Inc. are amended to include coverage related to the testing and treatment of COVID-19 described below, as well as to include continued coverage under the Plan(s), in accordance with the terms of the Families First Coronavirus Response Act (FFCRA), the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), and the Affordable Care Act, as applicable. The provisions below are in addition to and supersede any contrary provisions detailed in the Plan Document(s) and/or Summary Plan Descriptions.

The Plan(s) are hereby amended to include the provisions below, effective as of the date specified for each provision:

Coverage for the testing and diagnosis of COVID-19 in active plans includes the following:

- Coverage of testing authorized under federal law and diagnosis for COVID-19 without any cost sharing (e.g. deductibles, copayments or coinsurance) or prior authorization or other medical management requirements. This includes in- and out-of-network telehealth visits, office visits, ER visits and urgent care visits related to determining the need for a test or the actual test, and any related medical services during that time**. Effective January 1, 2022**
- Payment to testing providers according to the network contracted rate. In the absence of a negotiated rate for out-of-network providers, payment will be based on the price posted on the provider's web site**. Effective January 1, 2022**

Coverage for at-home over-the counter COVID-19 testing in active plans includes the following:

- Coverage of FDA approved at-home over-the-counter COVID-19 tests without any cost sharing (e.g. deductibles, copayments or coinsurance), prior authorization or other medical management requirements (hereinafter referred to as "At-Home COVID Tests").
- Coverage for At-Home COVID Tests is provided directly through the Plan's Prescription Benefits Administrator's (PBM) pharmacy network or preferred retailers with no upfront out of pocket costs.
- If the network pharmacy does not have any At-Home COVID Tests available or the pharmacy has not implemented operations to support direct coverage, Covered Persons can purchase At-Home COVID Tests at an out of network pharmacy or on-line and submit to the PBM for reimbursement which will be limited to the lesser of the cost of the test or $12.
- Coverage for At-Home COVID Tests is provided exclusively through the PBM benefit. At-Home COVID Tests are not otherwise covered or reimbursable under the Plan.
- The Plan will cover up to 8 At-Home COVID Tests per Covered Person, per 30-day period. **Effective January 15, 2022**

Coverage for the prevention of COVID-19 in active NGF plans includes the following:

- Coverage of COVID-19 preventive care and/or vaccinations that may become available with cost sharing waived within 15 days of recommendation for such services issued by either the United States Preventive Services Task Force (USPSTF) or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
  Effective January 1, 2022

Note: Coverage for COVID-19 treatment continues under the same terms of the Plan(s) applicable to treatment for other illnesses or injuries.

RECEIPT OF PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

I, the undersigned, acknowledge receipt of the Plan Document/Summary Plan Description booklet which outlines the group medical and prescription drug benefits for myself and all of my Eligible Dependents (if any), who meet the eligibility requirements stated in this Plan Document/Summary Plan Description.

I further understand that my rights under the Consolidated Omnibus Budget Reconciliation Act '85 (COBRA) for continuation of coverage and eligibility under the Special Enrollment Periods and Elections are outlined within the pages of this Plan Document/Summary Plan Description. By my following signature, I acknowledge receipt of the Plan Document/Summary Plan Description and that I am aware of my rights under COBRA and the Special Enrollment Periods and Elections.

The City of Savannah

_____

Employee Name (Please Print)

_____

Employee Signature

_____

Date

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I. ESTABLISHMENT OF PLAN

THIS INSTRUMENT established by The City of Savannah (hereinafter the "Employer") on this 1st day of January, 2022 sets forth The City of Savannah Employee Group Medical Plan – TCN effective as of January 1, 2022.

A. Establishment of Plan

The Employer hereby sets forth its group health plan known as The City of Savannah Employee Group Medical Plan – TCN (the "Plan"). The Plan is written for the sole and exclusive purpose of providing to the Employees, Retirees, and their Eligible Dependents employee medical and prescription drug benefits as described herein. These benefits have been established by the Employer and are provided on a self-funded basis. As such, the benefits are directly funded through and provided by the Employer, and the Employer has the sole responsibility and liability for payment of benefits under this Plan. Health Plans, Inc. is not the issuer, insurer, or provider of these benefits.

B. Effective Date

The Plan as described herein is effective as of January 1, 2022.

The Plan is subject to all of the conditions and provisions set forth in this document and subsequent amendments which are made a part of this Plan.

Important Notice: To obtain a list of In-Network Providers under this Plan, please visit www.CityofSavannahHealthPlan.com to search the online provider directory or call Quantum Health at (866) 360-9065 for additional information.

Please Note: Physicians and other medical professionals in the Plan's provider network participate through contractual arrangements that can be terminated either by a provider or by the Network administrator. In addition, a provider may leave the network because of retirement, relocation or other reasons. Therefore, it is not a guarantee that a provider will always be included in the list of In-Network Providers.

II. GENERAL INFORMATION

Plan Name:	The City of Savannah Employee Group Medical Plan - TCN
Effective Date:	January 1, 2022
Employer/Plan Sponsor:	The City of Savannah (the "Employer") 5515 Abercorn Street P.O. Box 1027 Savannah, GA 31402 (912) 651-6484
Employer Identification Number:	58-6000660
Group Number:	001WF8
Plan Administrator:	Employer (see above)
Claim Administrator:	Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 www.hpiTPA.com (877) 906-5730
Prescription Benefit Manager:	Express Scripts 1400 Riverport Drive Maryland Heights, MO 63043 (800) 524-4491
Member Inquiries and Precertification:	Quantum Health (866) 360-7926
Case Management Services:	Quantum Health 7400 Huntington Park Drive, Suite 100 Columbus, OH 43235 (866) 360-9065
COBRA Administrator:	Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 (866) 814-1751
Agent for Service of Legal Process:	Employer (see above)

Plan Cost:	Contributory
Plan Year Ends:	December 31st
Fiscal Year Ends:	December 31st
Loss of Benefits:	The Employer may terminate the Plan at any time or change the provisions of the Plan by a written instrument signed by a duly authorized officer of the Employer. An Employee's consent is not required to terminate or change the Plan. Coverage ends on the earlier of the day in which an Employee terminates employment or otherwise loses eligibility for coverage, or on the first day of the period in which a Covered Person fails to make any required contributions, if applicable. Contact the Plan Administrator to discuss what benefit extensions may apply or what arrangements may be made to continue coverage. In general, coverage may not be retroactively terminated under this Plan, except in cases of: a) fraud or intentional misrepresentation of material fact related to an Employee's or his or her dependents' coverage under the Plan, or b) failure to notify the Plan about a dependent's loss of eligibility for coverage under the Plan in a timely manner, or c) failure to pay required premiums or contributions in a timely manner. If coverage is retroactively terminated for any of these reasons, an Employee may be responsible for any benefit payments made during the relevant period. For any rescissions (retroactive termination of coverage that is related to fraud or intentional misrepresentation), the Plan Administrator will provide thirty (30) days advance written notice and an Employee will have the right to appeal the Plan's termination of coverage.

III. DEFINITIONS

The following words and phrases will have the following meanings when used in the Plan, unless a different meaning is plainly required by the context.

Actively at Work – the active expenditure of time and energy in the service of the Employer; an Employee will be deemed Actively at Work on each day of a regular paid day off and on a regular non-working day on which he or she is not Totally Disabled, if he or she was Actively at Work on the last preceding regular working day

Allowed Amount – the maximum amount the Plan will pay an Out-of-Network Provider for Covered Services that are **not** subject to the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA) (hereinafter referred to as "Non-NSA Covered Services"), minus any applicable Coinsurance, Co-payment or Deductible a Covered Person may be responsible for under the Plan. See the definition of "Qualifying Payment Amount" for the Covered Services that are subject to the NSA.

The Allowed Amount for Non-NSA Covered Services received from an Out-of-Network Provider is an amount that is consistent with historically accepted reimbursements, commercial pricing benchmarks, accepted Medicare rates, preferred provider contractual reimbursements , for outpatient dialysis the Usual and Reasonable Charge and geographic adjustments.

Covered Persons may be responsible for paying excess charges above the Allowed Amount for Non-NSA Covered Services after the Plan pays its portion.

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

(1) Federally funded or approved

(2) Conducted under a Food and Drug Administration (FDA) investigational new drug application; or

(3) Drug trials which are exempt from the requirements of an FDA investigational new drug application

Assignment of Benefits - an arrangement whereby the Covered Person assigns their right to seek and receive payment of eligible Covered Services to a provider using the Plan's internal and external administrative remedies, in accordance with the terms of this Plan, to a provider

Birthing Center – a facility primarily for the purpose of providing treatment for obstetrical care for which it was duly incorporated as a Birthing Center and registered as a Birthing Center with the existing state; the Birthing Center must also be licensed, if required by law

Calendar Year – the time period beginning January 1st and ending December 31st

Coinsurance – the percentage of coverage provided by the Plan, after the Covered Person has paid any applicable Deductible or Co-payment; for example, if Coinsurance is 80%, the Plan pays 80% and the Covered Person pays 20%, after any applicable Deductible or Co-payment

Contracted Rate – the negotiated amount the Plan has agreed to pay an In-Network Provider for Covered Services minus any applicable Coinsurance, Co-payment or Deductible a Covered Person may be responsible for under the Plan, except as provided by the outpatient dialysis provision

Co-payment – a fixed dollar amount a Covered Person pays for a Covered Service before any applicable Deductible or Coinsurance amount is applied, or as specified on the Schedule of Medical Benefits

Covered Person – an Employee, Retiree or dependent eligible for benefits and enrolled under this Plan

Covered Services – the products and services that a Covered Person is eligible to receive, or obtain payment for, under this Plan as specifically set forth under *Covered Services* in the *Medical Benefits* section

Custodial Care – services designed essentially to assist the Covered Person, whether disabled or not, in meeting the activities of daily living, including services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets and supervision over medication which can normally be self-administered; such services and supplies are deemed to be Custodial Care whenever and wherever furnished, without respect to the practitioner or provider by whom or by which they are prescribed, recommended or performed

Deductible – the amount payable by a Covered Person for services before the Plan's share of the cost is determined

Eligible Dependent –

(1) An Employee's or Retiree's* Spouse

(2) An Employee's domestic partner, provided that the Employee files an Affidavit of Domestic Partnership with the Plan Administrator before requesting to enroll

If Spouses or domestic partners are both Employees or Retirees, each can be covered individually or as the Eligible Dependent of the other. Neither can be covered both as an Employee or Retiree and as an Eligible Dependent. Only one of the two covered Spouses or domestic partners may cover Eligible Dependent children, if any.

Divorced Spouses and former domestic partners are ***not eligible*** for coverage under this Plan even if a court judgment governing the terms of the divorce or termination of

domestic partnership requires the Employee or Retiree to provide health coverage for the former Spouse or partner. Eligibility in the Plan will be terminated.

(3) An Employee's or Retiree's* child under age 26

(4) An Employee's or Retiree's* unmarried child age 26 or older who is Permanently and Totally Disabled, whose disability began before age 26, and for whom the Employee or Retiree submits proof of Permanent and Total Disability when requested at reasonable intervals

For purposes of this definition, "Permanently and Totally Disabled" means unable to engage in any substantial gainful activity by reason of a specific medically determinable physical or mental impairment which can be expected to last, or has lasted, for at least 12 months or result in death. Proof of Permanent and Total Disability must be certified by the child's Physician.

For the purposes of subsections (3) and (4) above, "Employee's or Retiree's* child" means:

(a) Natural child of the Employee or Retiree;

(b) Stepchild by marriage;

(c) Child of the Employee's Spouse for whom the Employee has legal responsibility resulting from a valid court order;

(d) Foster child the Employee expects to raise to adulthood and who lives with the Employee in a regular parent-child relationship. However, for Plan purposes, a "parent-child relationship" does not exist if one or both of the child's natural parents also lives with the Employee. Also, the Plan does not cover a foster child as long as the welfare agency provides all or part of the child's support;

(e) Child who has been legally adopted by or placed for adoption with the Employee or with the Spouse, or domestic partner by a court of competent jurisdiction (as detailed below);

Eligibility Due to Adoption or Placement for Adoption
Children placed for adoption with an enrolled Employee are eligible for coverage under the same terms and conditions as apply in the case of Eligible Dependent children who are natural children of enrolled Employees under the Plan, irrespective of whether or not the adoption has become final.

The terms "placement" or "being placed" for adoption with any person means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of the adoption. The child's placement with such person terminates upon the termination of such legal obligation.

The child's placement for adoption terminates upon the termination of such legal obligations. Upon termination of placement for adoption, the child's coverage terminates after the last day of the month the placement is terminated unless coverage must be continued pursuant to a Qualified Medical Child Support Order or continuation coverage is elected.

(f) Child of a covered domestic partner;

(g) Child for whom legal guardianship has been awarded to the Employee or to the Spouse, or domestic partner by a court of competent jurisdiction;

(h) Grandchild form whom legal guardianship has been awarded to the Employee by a court of competent jurisdiction; or

(i) Child/grandchild who is the subject of a Medical Child Support Order (as defined herein)

NOTE: In order for a Retiree to cover his or her Spouse, domestic partner, and eligible dependent children, the Retiree must be enrolled in either this Plan or the City Sponsored Medicare Advantage Plan at the time of his or her retirement, and the Spouse, domestic partner and eligible dependent children must be covered on the Plan the day immediately prior to the Employee's retirement. A Retiree's Spouse, domestic partner, or dependent child of a Spouse or domestic partner who is eligible for Medicare, unless Medicare eligibility is due to End Stage Renal Disease (ESRD), is not eligible for coverage under this Plan.

Note: Tax treatment for certain dependents. Federal tax law generally does not recognize former Spouses, legally separated Spouses, civil union or domestic partners, or the children of these partners, as dependents under the federal tax code unless the Spouse, partner, or child otherwise qualifies as a dependent under the Internal Revenue Code §152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who are covered under this Plan as Eligible Dependents, as additional income to the Employee or Retiree.

Employees and Retirees are obligated to inform the Plan Administrator of any change in a dependent's eligibility status within 31 days of such change. In the event that an ineligible dependent is found to have received benefits under this Plan, the Employee or Retiree will be responsible for any benefit payments made on that dependent's behalf.

Dependent Audit

The Plan Administrator reserves the right to conduct audits of all dependent eligibility. You may be asked to provide documentation to verify your dependents eligibility at any time. If you fail to comply, misrepresent or omit information, or if it is found that your dependent no longer meets the eligibility requirements, your dependent's coverage will be terminated retroactively, and you may be required to repay all cost incurred by the Plan. It may be grounds for corrective action, including termination of your employment.

Emergency Care – care administered in a Hospital, independent freestanding emergency department, clinic, urgent care center, or Physician's office for a Medical Emergency. Emergency Care includes: (1) an appropriate medical screening examination, including ancillary services routinely available to evaluate whether a Medical Emergency exists; and (2) such further medical examination and treatment as may be required to stabilize the Covered Person (regardless of the department of a Hospital or independent freestanding emergency department in which the further medical examination and treatment is furnished). Emergency Care does not include ambulance service to the facility where treatment is received.

Employee – any individual who is considered to be in an employer-employee relationship with the Employer for purposes of federal withholding taxes

Expense Incurred Date – for the purposes of this Plan, the date a service or supply to which it relates is provided

Experimental/Investigational – a drug, device, medical treatment, new technology, procedure or supply which is not recognized as eligible for coverage as defined below:

(1) The drug cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug, device, treatment, new technology, procedure or supply is furnished, or

(2) The drug, device, medical treatment, new technology, procedure or supply, or the patient's informed consent document utilized with the drug, device, treatment, new technology, procedure or supply requires review and approval by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval, or

(3) Reliable evidence shows that the drug, device, medical treatment, new technology, procedure or supply is the subject of on-going phase I or phase II clinical trials, is the research, experimental study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, except for drugs, devices, medical treatments, technology, procedures or supplies that would otherwise be covered under this Plan if they are provided to a Covered Person enrolled in an Approved Clinical Trial, are consistent with that standard of care for someone with the patient's diagnosis, are consistent with the study protocol for the Approved Clinical Trial and would be covered if the patient did not participate in the Approved Clinical Trial; or

(4) Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, new technology, procedure or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis

Reliable evidence will mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the

protocol(s) of another facility studying substantially the same drug, device, medical treatment, new technology, procedure or supply; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, new technology, procedure or supply.

FMLA – the Family and Medical Leave Act of 1993, as amended from time to time

FMLA Leave – a leave of absence that the Employer is required to extend to an Employee under the provisions of the FMLA

Home Health/Hospice Agency – an agency or organization which fully meets each of the following requirements:

(1) It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services;

(2) It has policies established by a professional group associated with the agency or organization, the professional group must include at least one Physician and at least one Registered Nurse (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a Physician or required licensed or Registered Nurse;

(3) It maintains a complete medical record on each patient; and

(4) It has an administrator

Hospice Plan of Care – a prearranged, written outline of care for the palliation and management of a Covered Person's terminal Illness

Hospital – a licensed facility which:

(1) Furnishes room and board;

(2) Is primarily engaged in providing, on an inpatient basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of doctors who are legally licensed to practice medicine;

(3) Regularly and continuously provides day and night nursing service by or under the supervision of a Physician;

(4) Is not, other than incidentally, a place for the aged or a nursing or convalescent home; and

(5) Is operated in accordance with the laws of the jurisdiction in which it is located pertaining to facilities identified as Hospitals

The term "Hospital" will include a facility specializing in the care and treatment for rehabilitation and mental or emotional Illness, disorder or disturbance, which would qualify

under this definition as a Hospital; or a residential treatment facility specializing in the care and treatment of mental illness, alcoholism, drug addiction or chemical dependency, provided such facility is duly licensed, if licensing is required by law in the jurisdiction where it is located, or provided such facility is accredited by the Joint Commission on Accreditation of Health Care Organizations and the Commission on Accreditation of Rehabilitation Facilities

Illness – a sickness or bodily disorder or disease, or mental health disease or disorder; an Illness due to causes which are the same or related to causes of a prior Illness, from which there has not been complete recovery will be considered a continuation of such prior Illness; the term "Illness" as used in this Plan will include pregnancy, childbirth, miscarriage, termination of pregnancy and any complications of pregnancy and related medical conditions

Infertility – the condition of a presumably healthy individual who is unable to conceive or produce conception

Injury – an event from an external agent resulting in damage to the physical structure of the body independent of Illness, and all complications arising from such external agent

In-Network Provider – a member of a network of Physicians, other licensed health care providers and/or health care facilities which provide medical services to Covered Persons under this Plan on the basis of a Contracted Rate; Covered Persons receiving Covered Services from an In-Network Provider are not responsible for any charges other than the cost sharing requirements (Deductibles, Coinsurance and/or Co-payments) and charges in excess of any specific benefit limits shown in the Schedule of Medical Benefits

The primary PPO Network selected by the Plan is The Care Network (TCN) through the Savannah Business Group (SBG). In-Network Hospitals are St. Joseph's/Candler Health System. Mayo Clinic and Nemours Children's Health in Jacksonville, FL also have a contract with the Plan and are considered In-Network when pre-certification rules are followed. In-Network Physicians are of two types: (1) Primary Care Physicians, and (2) Specialists. See the **Care Coordination Process** section for further information on how to obtain the highest level of paid benefit.

Covered Persons residing within The Care Network service area:
The Care Network service area includes Bryan, Chatham, Effingham, Liberty and Long Counties in Georgia and Beaufort and Jasper Counties in South Carolina. To receive maximum benefits, covered persons residing in The Care Network service area must access The Care Network providers when seeking services within the service area. The Care Network providers will be paid at the In-Network level as shown in the Schedule of Benefits. All other providers in The Care Network service area will be paid at the Out of Network benefit level.

Covered Persons who reside within The Care Network Service area may need to access care outside The Care Network area. The First Health Network is the designated PPO network for services outside the TCN service area. The First Health Network is a nationwide PPO network. Covered Persons should contact a Care Coordinator at

Quantum Health at 1-866-360-7926 for assistance with finding providers in the First Health Network.

Covered Persons residing outside The Care Network Service area:
Most Covered participants who reside outside The Care Network service area (i.e., retirees and covered dependents), will access the First Health Network as their primary network. Some Covered Persons who reside outside The Care Network service area (i.e., retirees and covered dependents), will be assigned to PHCS as their primary network in areas where the First Health Network does not have adequate provider access. Covered Persons assigned to PHCS will have the PHCS log on their ID card.

Inpatient Hospice Facility – a licensed facility which may or may not be part of a Hospital and which:

(1) Complies with licensing and other legal requirements in the jurisdiction where it is located;

(2) Is mainly engaged in providing inpatient palliative care for the terminally ill on a 24-hour basis under the supervision of a Physician or a Registered Nurse, if the care is not supervised by a Physician available on a prearranged basis;

(3) Provides pre-death and bereavement counseling;

(4) Maintains clinical records on all terminally ill persons; and

(5) Is not mainly a place for the aged or a nursing or convalescent home

Inpatient Hospice Facility also includes hospice facilities approved for a payment of Medicare hospice benefits

Intensive Outpatient Treatment – mental health or substance abuse care on an individual or group basis two (2) to five (5) days per week for two (2) to three (3) hours per day in a licensed Hospital, rural health center, community mental health center or substance abuse treatment facility

Medical Child Support Order - any valid judgment or order to provide health coverage for a dependent child of the Subscriber issued by any court or administrative body of the State of Georgia or any other state including an order in a final decree of divorce

Medical Emergency – the sudden onset of a medical condition of sufficient severity that an individual possessing an average knowledge of health and medicine could reasonably expect that failure to obtain medical treatment would seriously jeopardize the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child); or cause serious harm to bodily functions or any bodily organ or part; examples of medical emergencies include symptoms of heart attack and stroke; poisoning; loss of consciousness; severe difficulty breathing or shortness of breath; shock; convulsions; uncontrolled or severe bleeding; sudden

and/or severe pain; coughing or vomiting blood; sudden dizziness or severe weakness; profound change in vision; severe or persistent vomiting or diarrhea; and profound change in mental status

Medically Necessary (or Medical Necessity) – a service or supply which is a health care service that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that is:

(1) Legal and is provided in accordance with generally accepted standards of medical practice;

(2) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease;

(3) Not Experimental or Investigational; and

(4) Not primarily for the convenience of the patient, Physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community

Medicare – Title XVIII of the Social Security Act of 1965, as amended; Part A **–** means Medicare's Hospital plan, Part B **–** means the supplementary medical plan, and Part D – means the prescription drug plan

Mental Health Disorder – bipolar disorder, neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind

Morbid Obesity – as determined by a Covered Person's Physician, a Body Mass Index (BMI) greater than 40, or, in combination with significant medical co-morbidities, greater than 35

Nurse – a professional nurse who has a current active license(s) as a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.) or a Registered Nurse Midwife (R.N.M.), other than a nurse who ordinarily resides in the patient's home or who is a member of the patient's immediate family

Occupational Therapist – a health care provider who is licensed to provide occupational therapy services and who provides such services in the state(s) which issued the license(s)

Out-of-Network Provider – a licensed Physician, other licensed health care provider and/or health care facility which is not a member of a network of participating providers which provide medical services to Covered Persons under this Plan on the basis of a Contracted Rate; Covered Persons receiving Covered Services from an Out-of-Network Provider are responsible for any applicable Deductibles, Coinsurance and/or Co-payments, amounts in excess of any specific benefit limits shown in the Schedule of Medical Benefits for Out-of-Network Providers, and may

be responsible for any amounts in excess of the Allowed Amount for the services received, unless specifically stated otherwise in this Plan

Out-of-Pocket Maximum – the maximum amount a Covered Person pays for Covered Services under this Plan before the Plan pays at 100% as specified on the Schedule of Medical Benefits

Partial Hospitalization – mental health or substance abuse care on an individual or group basis five (5) days a week, eight (8) hours per day in a licensed Hospital, rural health center, community mental health center or substance abuse treatment facility

Physical Therapist – a health care provider who is licensed to provide physical therapy services and who provides such services in the state(s) which issued the license(s)

Physician – any licensed doctor of medicine, M.D., osteopathic Physician, D.O., dentist, D.D.S/D.M.D, podiatrist, on./D.S.C./D.P.M., doctor of chiropractic medicine, D.C., optometrist, O.D., or psychologist, Ph.D./Ed.D./Psy.D. Physician will also include a certified nurse midwife or a licensed independent social worker

Plan Appeals Evaluator or "PAE" – an entity appointed by the Plan Administrator to make final, binding decisions regarding the payment of benefits under the Plan pertaining to first and second level appeal determinations for claims

Plan Year – the twelve (12) month period ending on the date shown in the General Information section

Qualifying Payment Amount – the maximum amount the Plan will pay an Out-of-Network Provider for Covered Services that are subject to the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA) (hereinafter referred to as "NSA Covered Services"). Such NSA Covered Services are: emergency services rendered by Out-of-Network Providers for "Emergency Care" as defined in the section titled "Definitions"; air ambulance services rendered by Out-of-Network Providers of air ambulance services; and non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, provided the Covered Person has not validly waived the applicability of the NSA. The NSA Covered Services will be paid at the In-Network Provider Deductible, Co-payment and Coinsurance levels, subject to the Qualifying Payment Amount.

The Qualifying Payment Amount will be based on the median of the contracted rate for the same or similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law. The Qualifying Payment Amount will be determined in accordance with the NSA, as amended. If the provider does not accept the Qualifying Payment Amount as payment in full for NSA Covered Services, the amount payable may be determined by a Certified IDR Entity. A "Certified IDR Entity" shall mean an entity responsible for conducting determinations under the NSA and that has been properly certified in accordance with the NSA, as amended.

Any amendments to the foregoing methodology will be deemed to be included and in effect for the Plan as of the NSA amended date.

When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's Out-of-Network level of benefits, subject to the Allowed Amount.

Rehabilitation Hospital – a licensed facility or Hospital which is accredited by the Joint Commission on Accreditation of Health Care Organizations and the Commission on Accreditation of Rehabilitation Facilities

Retiree – a former covered Employee hired on January 1, 2008 and after will be eligible for continued medical coverage if he or she has ten (10) years of credited service, is eligible for a pension, has enrolled in the medical plan at the time of retirement from the City, and has not yet reached their 65th birthday. Employees hired prior to January 1, 2008 will be eligible for continued medical coverage if they have five (5) years of credited service, are eligible for a pension, are enrolled in the medical plan when they elect to retire from the City, and have not yet reached their 65th birthday.

Routine Nursery Care – routine room and board or nursery charges, Physician's or surgeon's charges, and any other related charges (including charges for circumcision) for a newborn child incurred while a patient in a Hospital, but not beyond the date the newborn child is first discharged from the Hospital

Service in the Uniformed Services – the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty

Skilled Nursing Facility – a licensed facility which:

(1) Provides, for compensation, room and board and 24-hour skilled nursing service under the full-time supervision of a Physician or a Registered Nurse; full-time supervision means a Physician or Registered Nurse is regularly on the premises at least 40 hours per week;

(2) Maintains a daily medical record for each patient;

(3) Has a written agreement of arrangement with a Physician to provide Emergency Care for its patients;

(4) Qualifies as an "extended care facility" under Medicare, as amended; and

(5) Has a written agreement with one or more Hospitals providing for the transfer of patients and medical information between the Hospital and convalescent nursing facility

Benefits will not be provided when:

(a) a Covered Person reaches the maximum level of recovery possible and no longer requires other than routine care;

(b) care is primarily custodial, not requiring definitive medical or 24-hour-a-day nursing service;

(c) care is for mental illness including drug addiction, chronic brain syndrome or alcoholism, and no specific medical conditions exist that require care in a Skilled Nursing Facility;

(d) a Covered Person is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;

(e) the care rendered is for other than skilled convalescent care.

Speech Therapist – a health care provider who is licensed to provide speech therapy services and who provides such services in the state(s) which issued the license(s)

Spouse - an individual lawfully married to a person. Individuals who have entered into a registered domestic partnership, civil union, or other similar relationship that is not a lawful marriage under state (or foreign) law are not considered Spouses for federal tax purposes. For more details, see IRS Publication 501.

Total Disability or Totally Disabled – the status of a covered Employee who, during any period when, as a result of Injury or Illness, is completely unable to perform the duties of any occupation for which he or she is reasonably fitted by training, education, or experience

Transplant Benefit Period – the period which begins on the date of the initial evaluation and ends on the date which is twelve (12) consecutive months following the date of the transplant; if the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant

Uniformed Service – the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in the time of war or emergency

Usual and Reasonable Charge - With respect to outpatient dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the

same services and/or supplies by all types of plans in the applicable market during the preceding Calendar Year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated

Waiting Period – the period of time, if any, an Employee must be employed by the Employer before becoming eligible to participate in this Plan

Well Child Care – treatment that is provided in accordance with the standards and frequencies recommended by the United States Preventive Services Task Force; coverage includes, but is not limited to; physical examinations, history, sensory screening, developmental screening and appropriate immunizations

IV. SCHEDULE OF MEDICAL BENEFITS

This Section contains a summary of the benefits made available under the Plan, as well as important information about how this Plan works. Please also refer to the section titled Medical Benefits for additional information about the benefits coverage and limitations under this Plan.

Precertification

Precertification is a process through which a Covered Person receives confirmation that benefits are payable under this Plan based on the Medical Necessity of the treatment recommended by or received from a health care provider. Precertification is not a guarantee of payment. Services which require precertification, regardless of whether the service is rendered inpatient, outpatient, or in an office setting, are identified on the following Schedule of Medical Benefits chart. Coverage and benefits are always subject to other requirements and provisions of the Plan, such as Plan limitations, exclusions and eligibility at the time the care and services are provided. Precertification is provided by an affiliate or a designee of Health Plans, Inc.

Call (866) 360-7926 prior to receiving services shown as requiring precertification to confirm the Medical Necessity of the proposed services.

The Plan does not cover services that precertification determines in advance are not Medically Necessary. If precertification is required but is not obtained, the Plan may not cover services that are determined not to have been Medically Necessary after they have been provided. If services rendered in an inpatient Hospital setting exceed the number of days precertified and the Hospital's reimbursement arrangement for those services is based on the diagnostic related group (DRG) pricing, the inpatient services will be paid according to the DRG priced amount. The Plan also reserves the right to deny coverage prospectively for any service that may not require precertification if it is determined not to be Medically Necessary.

IMPORTANT
Precertification for inpatient hospitalization is always required.

If a Covered Person is scheduled to be admitted to a Hospital, he or she must have the hospitalization precertified under the Plan at least three (3) business days prior to the date of admission or by the next business day in the case of emergency admissions.

The precertification requirement does not apply to maternity admissions unless it becomes apparent that the maternity admission will exceed 48 hours for a vaginal delivery or 96 hours for a cesarean delivery. In such cases, the inpatient stay that extends beyond the applicable 48 or 96-hour period must be precertified.

Failure to obtain precertification for inpatient services will result in a reduction in benefits in the amount of $500 per admission. Any reduction in benefits for inpatient services cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan.

Any penalty incurred due to failure to obtain notification or obtain a prior authorization for Covered Services is the Covered Person's responsibility.

PRECERTIFICATION REQUIREMENTS
The following procedures/benefits require pre-certification: • **Routine Colorectal Cancer Screenings** • **Inpatient hospitalization, including MH/SA services, skilled nursing facility and rehab hospital** • **Cochlear Implantations** • **Outpatient Surgical Procedures** • **Diagnostic Imaging for MRIs, MRAs, and PET-CT Scans (not required for stand-alone CT Scans)** • **Durable Medical Equipment in excess of $1,500 and all rentals** • **Genetic Testing** • **Home Health Care** • **Hospice (Inpatient and Outpatient)** • **Chemotherapy & Radiation Therapy (in office or outpatient facility)** • **Services rendered at Mayo Clinic, except for individuals in the Out-of-Area Plan** • **Dialysis/Hemodialysis** • **Organ and Tissue Transplants (must be pre-certified immediately upon the recipient being identified as a potential organ or tissue transplant recipient)** • **Orthotics in excess of $500** • **Prosthetics in excess of $500** • **Implantable Pumps** • **Scheduled Air Ambulance Transportation (all flight-based inter-facility patient transport must be precertified through Sentinal Air Medical Alliance, LLC at 1-877-542-8828 or a reduction or denial in benefits may result, subject to the Plan Administrator's discretion)** • **Sleep Studies** **Failure to obtain precertification will result in a $500 reduction in benefits for Inpatient Hospitalization or Skilled Nursing Facility and Rehabilitation Hospital admissions.**

Referrals for Specialty Care

To receive the highest level of benefits under the Plan, a Covered Person must receive an authorized referral from a PCP to any specialty Physician or other healthcare provider before visiting the specialist. A referral from a PCP is not required for Vision care (whether routine or medical), Dermatology, Obstetrics and Gynecology, Chiropractic Care, Nutritional/Diabetes Counseling, Mental and Nervous/Substance Abuse visits, and Emergency Room Physicians. The PCP is responsible for submitting the referral notice with all required information to the Care Coordinators, who will process the referral. (PCP offices have been provided with materials and education regarding this referral process.) While the referral process is initiated by the PCP, the Covered Person is ultimately responsible for ensuring that the referral authorization is in place before the specialty visit. Whenever possible, notice of this referral is sent to the Covered Person; however, Covered Persons can verify that the referral is in place by calling the Care Coordinators at 1-866-360-7926 or visiting www.CityofSavannahHealthPlan.com. Referral submissions will not be accepted after the specialty service has been received.

Other Questions Regarding Eligibility and Benefits

Please contact Quantum Health at for questions about Plan benefits or eligibility for covered dependents.

IMPORTANT: The Plan is not obligated to pay claims for Covered Persons who receive care determined not to be Medically Necessary or who fail to meet eligibility criteria for coverage.

BASIC OPTIONS 1 and 2

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY EXPRESS SCRIPTS	
Prescription Drug Expense & Mail Order Option **Step Therapy:** Certain prescription drug products are subject to step therapy requirements. In order to receive benefits for such prescription drug products or pharmaceutical products, Covered Persons may be required to use a different prescription drug product(s) or pharmaceutical product(s) first. To determine whether a particular prescription drug product or pharmaceutical product is subject to step therapy requirements, call Member Customer Care at the telephone number on your ID card. Substitution of a generic equivalent medication is required; if a Covered Person requests the brand name medication be filled, the Covered Person pays the difference between the brand and generic drug when a generic drug is available. The difference in cost does not apply toward the Prescription Drug Calendar Year Out-of-Pocket Maximum. U.S. Food and Drug Administration (FDA) approved contraceptive medications and devices are covered at 100% Tobacco cessations products are covered at 100%.	**Retail Card Program – You Pay:** (Up to a 30 day supply) $5 Co-payment per generic drug $25 Co-payment per preferred brand name drug $50 Co-payment per non-preferred brand name drug $75 Co-payment per specialty drug **Retail Card Pharmacy – You Pay:** (Up to a 90 day supply) $10 Co-payment per generic drug $50 Co-payment per preferred brand name drug $125 Co-payment per non-preferred brand name drug **GoStrong Retail Card Program – You Pay:** (Up to a 30 day supply – for diabetic drugs and testing supplies only) $0 Co-payment per generic drug $12.50 Co-payment per preferred brand name drug $35 Co-payment per non-preferred brand name drug **GoStrong Retail Card Pharmacy – You Pay:** (Up to a 90 day supply – for diabetic drugs and testing supplies only) $0 Co-payment per generic drug $25 Co-payment per preferred brand name drug $87.50 Co-payment per non-preferred brand name drug **Mail Order Pharmacy – You Pay:** (Up to a 90 day supply) $10 Co-payment per generic drug; $50 Co-payment per preferred brand name drug; $125 Co-payment per non-preferred brand name drug Note: Prescription drug Co-payments accumulate toward the prescription drug Out-of-Pocket Maximums. Once the prescription drug Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% for the balance of the Calendar Year.
Retail Card/Mail Order Pharmacy Calendar Year Out-of-Pocket Maximums: (Includes all applicable prescription drug Co-payments)	$3,450 per person; $6,900 per two person; $3,400 per family
Out-of-Network Pharmacy Coverage	Not Covered

BASIC OPTIONS 1 and 2

MEDICAL BENEFITS		
BENEFIT LEVELS	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Medical Calendar Year Deductible	Single Plan (Employee only): $1,300 Two Person (Employee + One): $1,300 per person, up to $2,600 per Two Person Family Plan (Employee & family): $1,300 per person, up to $3,900 per family	Single Plan (Employee only): $2,600 Two Person (Employee + One): $2,600 per person, up to $5,200 per Two Person Family Plan (Employee & family): $2,600 per person, up to $7,800 per family
Note: The Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the individual Deductible, claims will be paid for that individual. Otherwise, the entire family Deductible must be satisfied before claims will be paid for any family members. The family Deductible may be met by any combination of family members.		
Reimbursement Percentage ("Coinsurance")	80% of the Contracted Rate (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Calendar Year	50% of the Allowed Amount* (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Calendar Year
Medical Calendar Year Out-of-Pocket Maximums (Including all applicable Co-payments, Calendar Year Deductible and Coinsurance)	Single Plan (Employee only): $3,400 Two Person (Employee + One): $3,400 per person, up to $6,800 per Two Person Family Plan (Employee & family): $3,400 per person, up to $10,200 per family	Unlimited per person
Note: The Family Plan contains both an individual Out-of-Pocket Maximums and a family Out-of-Pocket Maximums. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximums is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximums may be met by any combination of family members.		

BASIC OPTIONS 1 and 2

IMPORTANT NOTES:

The In-Network Provider and Out-of-Network Provider Deductibles and Out-of-Pocket Maximums are separate and do not accumulate. Eligible expenses which track toward the In-Network Provider Deductible and In-Network Out-of-Pocket Maximums will not be credited toward the satisfaction of the Out-of-Network Provider Deductible and Out-of-Pocket Maximums and vice versa.

The following expenses are excluded from the Medical Out-of-Pocket Maximum(s):

- Precertification penalties
- Prescription drug Co-payments (Refer to Prescription Drug Benefit above for separate Prescription Out-of-Pocket Maximums)
- Chiropractic care

NOTE: Referrals for Specialty Care are required to receive the highest level of benefits under the Plan.

*Emergency services rendered by Out-of-Network Providers for "Emergency Care" as defined in the section titled "Definitions"; air ambulance services rendered by Out-of-Network Providers of air ambulance services; and non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, provided the Covered Person has not validly waived the applicability of the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA), will be paid at the In-Network Provider Deductible, Co-payment and Coinsurance levels, subject to the Qualifying Payment Amount.

When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's Out-of-Network level of benefits, subject to the Allowed Amount.

When services are rendered by an Out-of-Network Provider in any instance other than the reasons listed above, Covered Persons may be responsible for any amount above the Allowed Amount when services are rendered by an Out-of-Network Provider.

BASIC OPTIONS 1 and 2

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
****Routine Physical Exams** (Including routine and travel immunizations and flu shots) Up to one (1) exam per person, per Calendar year	100% (Deductible waived)	Not Covered
****Routine Well Child Care** (Including screenings, routine and travel immunizations and flu shots)	100% (Deductible waived)	Not Covered
****Fluoride Varnish** (Up to age 6) Up to four (4) varnish treatments per person, per Calendar year	100% (Deductible waived)	Not Covered
****Breastfeeding Support, Supplies and Counseling** (During pregnancy and/or in the postpartum period and rental or purchase of breastfeeding equipment) <u>Breast Pump Limits</u>: • Hospital Grade Breast Pumps: rental covered up to 3 months; • Electric Breast Pumps: rent or purchase, whichever is less; • Manual Breast Pumps: purchase	100% (Deductible waived)	Not Covered
**** Contraceptive Services and Supplies for Women** (FDA approved only; includes education and counseling)	100% (Deductible waived)	Not Covered
****Routine Gynecological/ Obstetrical Care** (Including preconception and prenatal services)	100% (Deductible waived)	Not Covered
****Routine Pap Smears** Up to one (1) per person, per Calendar year	100% (Deductible waived)	Not Covered

BASIC OPTIONS 1 and 2

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
**** Breast Cancer Screening including Routine Mammograms and BRCA testing** (Age 40 and older) Up to one (1) per person, per Calendar year	100% (Deductible waived)	Not Covered
One Baseline Mammogram	100% (Deductible waived)	Not Covered
****Routine Immunizations** (If not billed with an office visit; includes flu shots and travel immunization)	100% (Deductible waived)	Not Covered
****Routine Lab, X-rays, and Clinical Tests** (Including those related to maternity care)	100% (Deductible waived)	Not Covered
****Routine Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies** (Age 45 and older)	100% (Deductible waived)	Not Covered
****Lung Cancer Screening, including Low-Dose Computed Tomography (LDCT)** (Age 55 and older) Up to one (1) per person, per Calendar Year	100% (Deductible waived)	Not Covered
****Nutritional Counseling and Diabetes Education** Up to 4 visits per person, per Calendar Year	100% (Deductible waived)	Not Covered
****Smoking Cessation Counseling and Intervention** (Including smoking cessation clinics and programs)	100% (Deductible waived)	Not Covered

BASIC OPTIONS 1 and 2

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Routine Prostate Exams and Prostate-Specific Antigen (PSA) Screenings Up to one (1) per person, per Calendar Year	100% (Deductible waived)	Not Covered
****Abdominal Aortic Aneurysm Screening** (For men age 65 and over) Up to one (1) per person, per lifetime	100% (Deductible waived)	Not Covered
****Bone Density Screening** • Women • Men	 100% (Deductible waived) 80% (after Deductible)	 Not Covered Not Covered
VISION CARE	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Eyewear for Special Conditions (Includes lenses necessary to treat certain medical conditions; *see* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)

BASIC OPTIONS 1 and 2

PHYSICIAN SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Allergy Testing	$20 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Allergy Treatment	100% (Deductible waived)	50% Allowed Amount (after Deductible)
Anesthesia (Inpatient/Outpatient)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Chiropractic Services Up to 25* visits per person, per Calendar Year	80% (after Deductible)	80% Allowed Amount (after In-Network Deductible)
Maternity (Includes Physician delivery charges, prenatal and postpartum care) • Prenatal care • Physician delivery charges • Postnatal care	 100% (Deductible waived) $200 Co-payment, then 100% (Deductible waived) 100% (Deductible waived)	 50% Allowed Amount (after Deductible)
Physician Hospital Visits	80% (after Deductible)	50% Allowed Amount (after Deductible)
Physician Office Visits – Primary Care (Includes all related charges billed at time of visit)	$20 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Physician Office Visits - Specialist (Includes all related charges billed at time of visit)	With Referral: $35 Co-payment per visit, then 100% (Deductible waived) Without Referral: $75 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible) 50% Allowed Amount (after Deductible)
Second Surgical Opinion	$35 Co-payment per visit with Referral and $75 Co-payment per visit without Referral, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Surgery (Inpatient)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Surgery (Outpatient)	80% (after Deductible)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

BASIC OPTIONS 1 and 2

PHYSICIAN SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Surgery (Physician's office)	$20 PCP Co-payment per visit; $35 Specialist Co-payment per visit with Referral and $75 Co-payment per visit without Referral (up to $500), then 100% (Deductible waived) up to a $500 cap, then 80% (after Deductible)	50% Allowed Amount (after Deductible)

HOSPITAL SERVICES – INPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Case Management Services and Precertification are administered by Quantum Health – Providers should contact Quantum Health at 866-360-9065 regarding precertification requirements. Failure to obtain precertification will result in a $500 reduction of benefits.		
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits in the amount of $500 per admission.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **<u>Inpatient Hospital Co-payment:</u> A separate $500 Hospital Co-payment will apply to each inpatient admission in an Out-of-Network facility.** **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Hospital Room & Board Semi-private room or special care unit	80% (after Deductible)	$500 Co-payment per admission, then, 50% Allowed Amount (after Deductible)
Maternity Services Semi-private room or special care unit	80% (after Deductible)	$500 Co-payment per admission, then, 50% Allowed Amount (after Deductible)
Birthing Center	80% (after Deductible)	$500 Co-payment per admission, then, 80% Allowed Amount (after In-Network Deductible)
Newborn Care (Includes Physician visits & circumcision) Semi-private room or special care unit	80% (after Deductible)	50% Allowed Amount (after Deductible)

BASIC OPTIONS 1 and 2

HOSPITAL SERVICES – INPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Case Management Services and Precertification are administered by Quantum Health – Providers should contact Quantum Health at 866-360-9065 regarding precertification requirements. Failure to obtain precertification will result in a $500 reduction of benefits.		
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits in the amount of $500 per admission.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **<u>Inpatient Hospital Co-payment:</u> A separate $500 Hospital Co-payment will apply to each inpatient admission in an Out-of-Network facility.** **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Organ, Bone Marrow and Stem Cell Transplants *(See* Medical Benefits *section for other limitations*) Semi-private room or special care unit Transportation/food/lodging limits: $10,000 per Transplant	80% (after Deductible) <u>Travel/food/lodging</u>: 100% (Deductible waived)	50% Allowed Amount (after Deductible) <u>Travel/food/lodging:</u> 50% Allowed Amount (after Deductible)
Surgical Facility & Supplies	80% (after Deductible)	50% Allowed Amount (after Deductible)
Miscellaneous Hospital Charges	80% (after Deductible)	50% Allowed Amount (after Deductible)

BASIC OPTIONS 1 and 2

HOSPITAL SERVICES – OUTPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Case Management Services and Precertification are administered by Quantum Health – Providers should contact Quantum Health at 866-360-9065 regarding precertification requirements. Failure to obtain precertification will result in a $500 reduction in benefits.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency services rendered for "Emergency Care" as defined in the section titled "Definitions"; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Clinic Services (At a Hospital)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Emergency Room Expenses (Includes Facility, Lab, X-ray & Physician services) Co-payment is waived if admitted on an inpatient basis to a Hospital.	$200 Co-payment per visit, then 80% (after Deductible)	$200 Co-payment per visit, then 80% Allowed Amount (after In-Network Deductible)
Outpatient Department	80% (after Deductible)	50% Allowed Amount (after Deductible)
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc.	80% (after Deductible)	50% Allowed Amount (after Deductible)
Preadmission Testing	80% (after Deductible)	50% Allowed Amount (after Deductible)
Urgent Care Facility/Walk-In Clinic	$20 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)

BASIC OPTIONS 1 and 2

MENTAL HEALTH/ SUBSTANCE ABUSE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Case Management Services and Precertification are administered by Quantum Health – Providers should contact Quantum Health at 866-360-9065 regarding precertification requirements. Failure to obtain precertification will result in a $500 reduction in benefits.		
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits in the amount of $500 per admission.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Inpatient Hospitalization	80% (after Deductible)	$500 Co-payment per admission, then, 50% Allowed Amount (after Deductible)
Partial Hospitalization/Intensive Outpatient Treatment	80% (after Deductible)	50% Allowed Amount (after Deductible)
Inpatient Physician Visit	80% (after Deductible)	50% Allowed Amount (after Deductible)
Hospital Clinic Visit	$20 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Office Visit	$20 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Methadone Maintenance/ Treatment	$20 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)

BASIC OPTIONS 1 and 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for air ambulance services rendered by an Out-of-Network Provider of air ambulance services; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Ambulance Services (*See* Medical Benefits *section for limitations*) (Note: All flight-based inter-facility patient transport services require pre-certification from Sentinel Air Medical Alliance, LLC. Please contact Sentinel Air Medical Alliance, LLC at 1-877-542-8828)	80% (after Deductible)	80% Allowed Amount (after In-Network Deductible)
Autism Spectrum Disorders Treatment (Includes Applied Behavioral Analysis (ABA); benefit limits do not apply to occupational, physical and speech therapies; precertification *is required* for ABA; s*ee* Medical Benefits *section for limitations*) Note: Screenings are covered under Preventive Care	Benefits are based on services provided	Benefits are based on services provided
Bariatric Surgery (*Precertification for Medical Necessity required*; *see* Medical Benefits *section for other limitations)*	Mayo Clinic of Jacksonville: 80% (after Deductible) All Other Providers, contact Quantum: $500 Co-payment per admission, then 80% (after Deductible)	$500 Co-payment per admission, then 50% Allowed Amount (after Deductible)
Cardiac Rehabilitation (Phase 1 and 2 only; *see* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Chemotherapy & Radiation Therapy	80% (after Deductible)	50% Allowed Amount (after Deductible)
Clinical Trials – Routine Services during Approved Clinical Trials (Limited to routine Covered Services under the Plan, including Hospital visits, laboratory, and imaging services; see Medical Benefits section for other limitations)	Benefits are based on services provided	Benefits are based on services provided
Cochlear Implants	80% (after Deductible)	50% Allowed Amount (after Deductible)

BASIC OPTIONS 1 and 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Dental/Oral Services (Includes excision of impacted wisdom teeth; *see* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Diabetes The following services will be covered with no cost sharing: • One (1) eye exam per person, per Calendar Year • One (1) foot exam per person, per Calendar Year	 100% (Deductible waived) 100% (Deductible waived)	 Not Covered Not Covered
Diabetes Self-Management Training and Education and/or Nutritional Counseling (GoStrong Diabetes Program) Up to four (4) hours each of nutrition and diabetes education per person, per Calendar Year	St. Joseph's/Candler Center: 100% (Deductible waived) All Other Providers: Not Covered	Not Covered Not Covered
Diagnostic Imaging (MRI, MRA, PET and PET-CT Scans)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Diagnostic X-ray and Laboratory (Outpatient)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
Dialysis/Hemodialysis - Outpatient	100% Usual and Reasonable Charge (after Deductible) **NOTE: Outpatient Dialysis Treatment claims are subject to specific conditions which do not apply to other types of claims. *Please refer to* Dialysis Treatment Outpatient description in Medical Benefits *section for other limitations.***	
Durable Medical Equipment *(See* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Early Intervention Services (*See* Medical Benefits *section for other limitations*) (Up to age 3)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Family Planning (Including but not limited to consultations and diagnostic tests) **For Women** (See also Prescription Drug Benefit and Preventive Care Section) **For Men**	 100% (Deductible waived) 80% (after Deductible)	 Not Covered Not Covered

BASIC OPTIONS 1 and 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Genetic Counseling, Testing and Related Services *(Precertification for Medical Necessity required for genetic testing*) Up to one (1)* test per person, per lifetime (except for BRCA Testing) and counseling is limited to three (3)* visits per person, per Calendar Year for both pre- and post-genetic testing (Note: Coverage is provided for BRCA Testing – See Breast Cancer Screening in Preventive Care Services; precertification is not required)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Hearing Aids (For covered dependent children only when due to congenital abnormality)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Home Health Care *(See* Medical Benefits *section for other limitations)* Up to 120* visits per person, per Calendar Year	$20 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Hospice Care (Inpatient/Outpatient) *(See* Medical Benefits *section for other limitations)* Up to 180* days per person, per Lifetime	100% (Deductible waived)	50% Allowed Amount (after Deductible)
Injectables	80% (after Deductible)	50% Allowed Amount (after Deductible)
Marital Counseling	$20 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Medical and Enteral Formula (Including metabolic formula; *see* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Modified Low Protein Food Products (*See* Medical Benefits *section for limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)

Neuromuscular Stimulator Equipment including TENS	80% (after Deductible)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

BASIC OPTIONS 1 and 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Occupational Therapy (For treatment due to Illness, Injury or developmental delays*; see* Medical Benefits *section for other limitations)* Up to 30* visits per person, per Calendar Year	80% (after Deductible)	50% Allowed Amount (after Deductible)
Orthotics (Includes foot orthotics; s*ee* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Physical Therapy (For treatment due to Illness, Injury or developmental delays*; see* Medical Benefits *section for other limitations)* Up to 30* visits per person, per Calendar Year	80% (after Deductible)	50% Allowed Amount (after Deductible)
Podiatry Care *(See* Medical Benefits *section for limitations*)	$35 Co-payment per visit with Referral and $75 Co-payment per visit without Referral, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Private Duty Nursing *(See* Medical Benefits *section for other limitations)*	Inpatient: 80% (after Deductible) Outpatient: $20 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Prosthetics *(See* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Rehabilitation Hospital *(Precertification for Medical Necessity required*; s*ee* Medical Benefits *section for other limitations*) Up to 90* days per person, per Calendar Year	80% (after Deductible)	$500 Co-payment per admission, then, 80% Allowed Amount (after In-Network Deductible)
Respiratory Therapy	80% (after Deductible)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

BASIC OPTIONS 1 and 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Skilled Nursing Facility/Extended Care Facility *(Precertification for Medical Necessity required; see* Medical Benefits *section for other limitations*) Up to 90* days per person, per Calendar Year	80% (after Deductible)	$500 Co-payment per admission, then, 80% Allowed Amount (after In-Network Deductible)
Sleep Studies	80% (after Deductible)	50% Allowed Amount (after Deductible)
Speech Therapy (For treatment due to Illness, Injury or developmental delays*; see* Medical Benefits *section for other limitations)* Up to 30* visits per person, per Calendar Year	80% (after Deductible)	50% Allowed Amount (after Deductible)
Telemedicine (Applies to medical and behavioral health services; includes Doctor on Demand; *see* Medical Benefits *section for additional information*) All other virtual visits with a Provider with whom a Covered Person has established relationship, including, but not limited to Occupational Therapy, Physical Therapy and Speech Therapy	$20 Co-payment per visit, then 100% (Deductible waived) Paid based on services provided	50% Allowed Amount (after Deductible) Paid based on services provided
Temporomandibular Joint Disorders (TMJ) Treatment *(See* Medical Benefits *section for other limitations)* Up to $1,000* per person, per Calendar Year	80% (after Deductible)	50% Allowed Amount (after Deductible)
Voluntary Sterilization **For Women** **For Men**	 100% (Deductible waived) 80% (after Deductible)	 Not Covered Not Covered
Voluntary Termination of Pregnancy	80% (after Deductible)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

PLUS OPTIONS 1 and 2

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY EXPRESS SCRIPTS	
Prescription Drug Expense & Mail Order Option **Step Therapy:** Certain prescription drug products are subject to step therapy requirements. In order to receive benefits for such prescription drug products or pharmaceutical products, Covered Persons may be required to use a different prescription drug product(s) or pharmaceutical product(s) first. To determine whether a particular prescription drug product or pharmaceutical product is subject to step therapy requirements, call Member Customer Care at the telephone number on your ID card. Substitution of a generic equivalent medication is required; if a Covered Person requests the brand name medication be filled, the Covered Person pays the difference between the brand and generic drug when a generic drug is available. The difference in cost does not apply toward the Prescription Drug Calendar Year Out-of-Pocket Maximum.	**Retail Card Program – You Pay:** (Up to a 30 day supply) $5 Co-payment per generic drug $25 Co-payment per preferred brand name drug $50 Co-payment per non-preferred brand name drug $75 Co-payment per specialty drug **Retail Card Pharmacy – You Pay:** (Up to a 90 day supply) $10 Co-payment per generic drug $50 Co-payment per preferred brand name drug $125 Co-payment per non-preferred brand name drug **GoStrong Retail Card Program – You Pay:** (Up to a 30 day supply – for diabetic drugs and testing supplies only) $0 Co-payment per generic drug $12.50 Co-payment per preferred brand name drug $35 Co-payment per non-preferred brand name drug **GoStrong Retail Card Pharmacy – You Pay:** (Up to a 90 day supply– for diabetic drugs and testing supplies only) $0 Co-payment per generic drug $25 Co-payment per preferred brand name drug $87.50 Co-payment per non-preferred brand name drug **Mail Order Pharmacy – You Pay:** (Up to a 90 day supply) $10 Co-payment per generic drug; $50 Co-payment per preferred brand name drug; $125 Co-payment per non-preferred brand name drug Note: Prescription drug Co-payments accumulate toward the prescription drug Out-of-Pocket Maximums. Once the prescription drug Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% for the balance of the Calendar Year. U.S. Food and Drug Administration (FDA) approved contraceptive medications and devices are covered at 100% Tobacco cessations products are covered at 100%.
Retail Card/Mail Order Pharmacy Calendar Year Out-of-Pocket Maximums: (Includes all applicable prescription drug Co-payments)	$4,650 per person; $9,300 per two person; $7,100 per family
Out-of-Network Pharmacy Coverage	Not Covered

PLUS OPTIONS 1 and 2

MEDICAL BENEFITS		
BENEFIT LEVELS	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Medical Calendar Year Deductible	Single Plan (Employee only): $500 Two Person (Employee + One): $500 per person, up to $1,000 per Two Person Family Plan (Employee & family): $500 per person, up to $1,500 per family	Single Plan (Employee only): $1,000 Two Person (Employee + One): $1,000 per person, up to $2,000 per Two Person Family Plan (Employee & family): $1,000 per person, up to $3,000 per family
Note: The Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the individual Deductible, claims will be paid for that individual. Otherwise, the entire family Deductible must be satisfied before claims will be paid for any family members. The family Deductible may be met by any combination of family members.		
Medical Calendar Year Deductible Carryover	**NO**	
Reimbursement Percentage ("Coinsurance")	80% of the Contracted Rate (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Calendar Year	50% of the Allowed Amount* (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Calendar Year
Medical Calendar Year Out-of-Pocket Maximums (Including all applicable Co-payments, Calendar Year Deductible and Coinsurance)	Single Plan (Employee only): $2,200 Two Person (Employee + One): $2,200 per person, up to $4,400 per Two Person Family Plan (Employee & family): $2,200 per person, up to $6,600 per family	Unlimited per person
Note: The Family Plan contains both an individual Out-of-Pocket Maximums and a family Out-of-Pocket Maximums. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximums is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximums may be met by any combination of family members. **The In-Network Provider and Out-of-Network Provider Deductibles and Out-of-Pocket Maximums are separate and do not accumulate. Eligible expenses which track toward the In-Network Provider Deductible and In-Network Out-of-Pocket Maximums will not be credited toward the satisfaction of the Out-of-Network Provider Deductible and Out-of-Pocket Maximums and vice versa.** **The following expenses are excluded from the Medical Out-of-Pocket Maximum(s):** • Precertification penalties • Prescription drug Co-payment (Refer to Prescription Drug Benefit above for separate Prescription Out-of-Pocket Maximums) • Chiropractic care ***The Covered Person is also responsible to pay any amount above the Allowed Amount when services are rendered by an Out-of-Network Provider.*** ***NOTE: Referrals for Specialty Care are required to receive the highest level of benefits under the Plan.***		

PLUS OPTIONS 1 and 2

IMPORTANT NOTES:

*Emergency services rendered by Out-of-Network Providers for "Emergency Care" as defined in the section titled "Definitions"; air ambulance services rendered by Out-of-Network Providers of air ambulance services; and non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, provided the Covered Person has not validly waived the applicability of the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA), will be paid at the In-Network Provider Deductible, Co-payment and Coinsurance levels, subject to the Qualifying Payment Amount.

When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's Out-of-Network level of benefits, subject to the Allowed Amount.

When services are rendered by an Out-of-Network Provider in any instance other than the reasons listed above, Covered Persons may be responsible for any amount above the Allowed Amount when services are rendered by an Out-of-Network Provider.

PLUS OPTIONS 1 and 2

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
****Routine Physical Exams** (Including routine and travel immunizations and flu shots) Up to one (1) exam per person, per Calendar year	100% (Deductible waived)	Not Covered
****Routine Well Child Care** (Including screenings, routine and travel immunizations and flu shots)	100% (Deductible waived)	Not Covered
****Fluoride Varnish** (Up to age 6) Up to four (4) varnish treatments per person, per Calendar year	100% (Deductible waived)	Not Covered
****Breastfeeding Support, Supplies and Counseling** (During pregnancy and/or in the postpartum period and rental or purchase of breastfeeding equipment) <u>Breast Pump Limits</u>: • Hospital Grade Breast Pumps: rental covered up to 3 months; • Electric Breast Pumps: rent or purchase, whichever is less; • Manual Breast Pumps: purchase	100% (Deductible waived)	Not Covered
**** Contraceptive Services and Supplies for Women** (FDA approved only; includes education and counseling)	100% (Deductible waived)	Not Covered
****Routine Gynecological/ Obstetrical Care** (Including preconception and prenatal services)	100% (Deductible waived)	Not Covered
****Routine Pap Smears** Up to one (1) per person, per Calendar year	100% (Deductible waived)	Not Covered

PLUS OPTIONS 1 and 2

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
**** Breast Cancer Screening including Routine Mammograms and BRCA testing** (Age 40 and older) Up to one (1) per person, per Calendar year	100% (Deductible waived)	Not Covered
One Baseline Mammogram	100% (Deductible waived)	Not Covered
****Routine Immunizations** (If not billed with an office visit; includes flu shots and travel immunization)	100% (Deductible waived)	Not Covered
****Routine Lab, X-rays, and Clinical Tests** (Including those related to maternity care)	100% (Deductible waived)	Not Covered
****Routine Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies** (Age 45 and older)	100% (Deductible waived)	Not Covered
****Lung Cancer Screening, including Low-Dose Computed Tomography (LDCT)** (Age 55 and older) Up to one (1) per person, per Calendar Year	100% (Deductible waived)	Not Covered
****Nutritional Counseling and Diabetes Education** Up to 4 visits per person, per Calendar Year	100% (Deductible waived)	Not Covered
****Smoking Cessation Counseling and Intervention** (Including smoking cessation clinics and programs)	100% (Deductible waived)	Not Covered

PLUS OPTIONS 1 and 2

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Routine Prostate Exams and Prostate-Specific Antigen (PSA) Screenings Up to one (1) per person, per Calendar Year	100% (Deductible waived)	Not Covered
****Abdominal Aortic Aneurysm Screening** (For men age 65 and over) Up to one (1) per person, per lifetime	100% (Deductible waived)	Not Covered
****Bone Density Screening** • Women • Men	 100% (Deductible waived) 80% (after Deductible)	 Not Covered Not Covered

VISION CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Eyewear for Special Conditions (Includes lenses necessary to treat certain medical conditions; *see* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)

PLUS OPTIONS 1 and 2

PHYSICIAN SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Allergy Testing	$15 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Allergy Treatment	100% (Deductible waived)	50% Allowed Amount (after Deductible)
Anesthesia (Inpatient/Outpatient)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Chiropractic Services Up to 25* visits per person, per Calendar Year	80% (after Deductible)	80% Allowed Amount (after In-Network Deductible)
Maternity (Includes Physician delivery charges, prenatal and postpartum care) • Prenatal care • Physician delivery charges • Postnatal care	 100% (Deductible waived) $200 Co-payment, then 100% (Deductible waived) 100% (Deductible waived)	 50% Allowed Amount (after Deductible)
Physician Hospital Visits	80% (after Deductible)	50% Allowed Amount (after Deductible)
Physician Office Visits – Primary Care (Includes all related charges billed at time of visit)	$15 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Physician Office Visits - Specialist (Includes all related charges billed at time of visit)	With Referral: $25 Co-payment per visit, then 100% (Deductible waived) Without Referral: $50 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Second Surgical Opinion	$25 Co-payment per visit with Referral and $50 Co-payment per visit without Referral, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Surgery (Inpatient)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Surgery (Outpatient)	80% (after Deductible)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

PLUS OPTIONS 1 and 2

PHYSICIAN SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Surgery (Physician's office)	$15 PCP Co-payment per visit; $25 Specialist Co-payment per visit with Referral and $50 Co-payment per visit without Referral, then 100% (Deductible waived) up to a $500 cap; then 80% (after Deductible)	50% Allowed Amount (after Deductible)

HOSPITAL SERVICES – INPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Case Management Services and Precertification are administered by Quantum Health – Providers should contact Quantum Health at 866-360-9065 regarding precertification requirements. Failure to obtain precertification will result in a $500 reduction of benefits.		
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits in the amount of $500 per admission.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **<u>Inpatient Hospital Co-payment:</u> A separate $500 Hospital Co-payment will apply to each inpatient admission in an Out-of-Network facility.** **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Hospital Room & Board Semi-private room or special care unit	80% (after Deductible)	$500 Co-payment per admission, then, 50% Allowed Amount (after Deductible)
Maternity Services Semi-private room or special care unit	80% (after Deductible)	$500 Co-payment per admission, then, 50% Allowed Amount (after Deductible)
Birthing Center	80% (after Deductible)	$500 Co-payment per admission, then, 80% Allowed Amount (after In-Network Deductible)
Newborn Care (Includes Physician visits & circumcision) Semi-private room or special care unit	80% (after Deductible)	50% Allowed Amount (after Deductible)

PLUS OPTIONS 1 and 2

HOSPITAL SERVICES – INPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Case Management Services and Precertification are administered by Quantum Health – Providers should contact Quantum Health at 866-360-9065 regarding precertification requirements. Failure to obtain precertification will result in a $500 reduction of benefits.		
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits in the amount of $500 per admission.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **<u>Inpatient Hospital Co-payment:</u> A separate $500 Hospital Co-payment will apply to each inpatient admission in an Out-of-Network facility.** **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Organ, Bone Marrow and Stem Cell Transplants *(See* Medical Benefits *section for other limitations*) Semi-private room or special care unit Transportation/food/lodging limits: $10,000 per Transplant	80% (after Deductible) <u>Travel/food/lodging</u>: 100% (Deductible waived)	50% Allowed Amount (after Deductible) <u>Travel/food/lodging:</u> 50% Allowed Amount (after Deductible)
Surgical Facility & Supplies	80% (after Deductible)	50% Allowed Amount (after Deductible)
Miscellaneous Hospital Charges	80% (after Deductible)	50% Allowed Amount (after Deductible)

PLUS OPTIONS 1 and 2

HOSPITAL SERVICES – OUTPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Case Management Services and Precertification are administered by Quantum Health – Providers should contact Quantum Health at 866-360-9065 regarding precertification requirements. Failure to obtain precertification will result in a $500 reduction in benefits.		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency services rendered for "Emergency Care" as defined in the section titled "Definitions"; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Clinic Services (At a Hospital)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Emergency Room Expenses (Includes Facility, Lab, X-ray & Physician services) Co-payment is waived if admitted on an inpatient basis to a Hospital.	$200 Co-payment per visit, then 80% (after Deductible)	$200 Co-payment per visit, then 80% Allowed Amount (after In-Network Deductible)
Outpatient Department	80% (after Deductible)	50% Allowed Amount (after Deductible)
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc.	80% (after Deductible)	50% Allowed Amount (after Deductible)
Preadmission Testing	80% (after Deductible)	50% Allowed Amount (after Deductible)
Urgent Care Facility/Walk-In Clinic	$15 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)

PLUS OPTIONS 1 and 2

MENTAL HEALTH/ SUBSTANCE ABUSE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Case Management Services and Precertification are administered by Quantum Health – Providers should contact Quantum Health at 866-360-9065 regarding precertification requirements. Failure to obtain precertification will result in a $500 reduction in benefits.		
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits in the amount of $500 per admission.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Inpatient Hospitalization	80% (after Deductible)	$500 Co-payment per admission, then, 50% Allowed Amount (after Deductible)
Partial Hospitalization/Intensive Outpatient Treatment	80% (after Deductible)	50% Allowed Amount (after Deductible)
Inpatient Physician Visit	80% (after Deductible)	50% Allowed Amount (after Deductible)
Hospital Clinic Visit	$15 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Office Visit	$15 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Methadone Maintenance/ Treatment	$15 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)

PLUS OPTIONS 1 and 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for air ambulance services rendered by an Out-of-Network Provider of air ambulance services; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Ambulance Services (*See* Medical Benefits *section for limitations*) (Note: All flight-based inter-facility patient transport services require pre-certification from Sentinel Air Medical Alliance, LLC. Please contact Sentinel Air Medical Alliance, LLC at 1-877-542-8828)	80% (after Deductible)	80% Allowed Amount (after In-Network Deductible)
Autism Spectrum Disorders Treatment (Includes Applied Behavioral Analysis (ABA); benefit limits do not apply to occupational, physical and speech therapies; precertification *is required* for ABA; s*ee* Medical Benefits *section for limitations*) Note: Screenings are covered under Preventive Care	Benefits are based on services provided	Benefits are based on services provided
Bariatric Surgery (*Precertification for Medical Necessity required*; *see* Medical Benefits *section for other limitations)*	Mayo Clinic of Jacksonville: 80% (after Deductible) All Other Providers contact Quantum: $500 Co-payment per admission, then 80% (after Deductible)	$500 Co-payment per admission, then 50% Allowed Amount (after Deductible)
Cardiac Rehabilitation (Phase 1 and 2 only; *see* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Chemotherapy & Radiation Therapy	80% (after Deductible)	50% Allowed Amount (after Deductible)
Clinical Trials – Routine Services during Approved Clinical Trials (Limited to routine Covered Services under the Plan, including Hospital visits, laboratory, and imaging services; see Medical Benefits section for other limitations)	Benefits are based on services provided	Benefits are based on services provided
Cochlear Implants	80% (after Deductible)	50% Allowed Amount (after Deductible)
Dental/Oral Services (Includes excision of impacted wisdom teeth; *see* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)

PLUS OPTIONS 1 and 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Diabetes The following services will be covered with no cost sharing: • One (1) eye exam per person, per Calendar Year • One (1) foot exam per person, per Calendar Year	 100% (Deductible waived) 100% (Deductible waived)	 Not Covered Not Covered
Diabetes Self-Management Training and Education and/or Nutritional Counseling **(GoStrong Diabetes Program)** Up to four (4) hours each of nutrition and diabetes education per person, per Calendar Year	St. Joseph's/Candler Center: 100% (Deductible waived) All Other Providers: Not Covered	Not Covered Not Covered
Diagnostic Imaging (MRI, MRA, PET and PET-CT Scans)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Diagnostic X-ray and Laboratory (Outpatient)	100% (Deductible waived)	50% Allowed Amount (after Deductible)
Dialysis/Hemodialysis - Outpatient	100% Usual and Reasonable Charge (after Deductible) **NOTE: Outpatient Dialysis Treatment claims are subject to specific conditions which do not apply to other types of claims. *Please refer to* Dialysis Treatment Outpatient description in Medical Benefits *section for other limitations.***	
Durable Medical Equipment *(See* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Early Intervention Services (*See* Medical Benefits *section for other limitations*) (Up to age 3)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Family Planning (Including but not limited to consultations and diagnostic tests) **For Women** (See also Prescription Drug Benefit and Preventive Care Section) **For Men**	 100% (Deductible waived) 80% (after Deductible)	 Not Covered Not Covered

PLUS OPTIONS 1 and 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Genetic Counseling, Testing and Related Services *(Precertification for Medical Necessity required for genetic testing*) Up to one (1)* test per person, per lifetime (except for BRCA Testing) and counseling is limited to three (3)* visits per person, per Calendar Year for both pre- and post-genetic testing (Note: Coverage is provided for BRCA Testing – See Breast Cancer Screening in Preventive Care Services; precertification is not required)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Hearing Aids (For covered dependent children only when due to congenital abnormality)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Home Health Care *(See* Medical Benefits *section for other limitations)* Up to 120* visits per person, per Calendar Year	$20 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Hospice Care (Inpatient/Outpatient) *(See* Medical Benefits *section for other limitations)* Up to 180* days per person, per Lifetime	100% (Deductible waived)	50% Allowed Amount (after Deductible)
Injectables	80% (after Deductible)	50% Allowed Amount (after Deductible)
Marital Counseling	$15 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Medical and Enteral Formula (Including metabolic formula; *see* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Modified Low Protein Food Products (*See* Medical Benefits *section for limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)

Neuromuscular Stimulator Equipment including TENS	80-% (after Deductible)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

PLUS OPTIONS 1 and 2

OTHER SERVICES & SUPPLIES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Occupational Therapy (For treatment due to Illness, Injury or developmental delays*; see* Medical Benefits *section for other limitations)* Up to 30* visits per person, per Calendar Year	80% (after Deductible)	50% Allowed Amount (after Deductible)
Orthotics (Includes foot orthotics; s*ee* Medical Benefits *section for other limitations*)	80% (after Deductible)	50% Allowed Amount (after Deductible)
Physical Therapy (For treatment due to Illness, Injury or developmental delays*; see* Medical Benefits *section for other limitations)* Up to 30* visits per person, per Calendar Year	80% (after Deductible)	50% Allowed Amount (after Deductible)
Podiatry Care *(See* Medical Benefits *section for limitations*)	$25 Co-payment per visit with Referral and $50 Co-payment per visit without Referral, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Private Duty Nursing *(See* Medical Benefits *section for other limitations)*	Inpatient: 80% (after Deductible) Outpatient: $15 Co-payment per visit, then 100% (Deductible waived)	50% Allowed Amount (after Deductible)
Prosthetics *(See* Medical Benefits *section for other limitations)*	80% (after Deductible)	50% Allowed Amount (after Deductible)
Rehabilitation Hospital *(Precertification for Medical Necessity required*; *see* Medical Benefits *section for other limitations*) Up to 90* days per person, per Calendar Year	80% (after Deductible)	$500 Co-payment per admission, then, 80% Allowed Amount (after In-Network Deductible)
Respiratory Therapy	80% (after Deductible)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

PLUS OPTIONS 1 and 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Skilled Nursing Facility/Extended Care Facility *(Precertification for Medical Necessity required; see* Medical Benefits *section for other limitations*) Up to 90* days per person, per Calendar Year	80% (after Deductible)	$500 Co-payment per admission, then, 80% Allowed Amount (after In-Network Deductible)
Sleep Studies	80% (after Deductible)	50% Allowed Amount (after Deductible)
Speech Therapy (For treatment due to Illness, Injury or developmental delays*; see* Medical Benefits *section for other limitations)* Up to 30* visits per person, per Calendar Year	80% (after Deductible)	50% Allowed Amount (after Deductible)
Telemedicine (Applies to medical and behavioral health services; includes Doctor on Demand; *see* Medical Benefits *section for additional information*) All other virtual visits with a Provider with whom a Covered Person has established relationship, including, but not limited to Occupational Therapy, Physical Therapy and Speech Therapy	$15 Co-payment per visit, then 100% (Deductible waived) Paid based on services provided	50% Allowed Amount (after Deductible) Paid based on services provided
Temporomandibular Joint Disorders (TMJ) Treatment *(See* Medical Benefits *section for other limitations)* Up to $1,000* per person, per Calendar Year	80% (after Deductible)	50% Allowed Amount (after Deductible)
Voluntary Sterilization **For Women** **For Men**	 100% (Deductible waived) 80% (after Deductible)	 Not Covered Not Covered
Voluntary Termination of Pregnancy	80% (after Deductible)	50% Allowed Amount (after Deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

DISEASE MANAGEMENT AND PREVENTION PROGRAMS
BASIC OPTIONS AND PLUS OPTIONS

TYPE OF SERVICE	IN-NETWORK PROVIDERS (PPO Contracted Rates)	OUT-OF-NETWORK PROVIDERS
Weigh to GO! **Contact St Joseph's/Candler Wellness Center** **5353 Reynolds Street** **Phone: 912-819-8800**	Level II: BMI 30 to 39.9 100% Level III: BMI $\geq$ 40 100% Maintenance Program 100% - Consultation with Exercise Physiologist, customized exercise prescription, personal training - Lab work for risk factor analysis and follow-up evaluation - Resting Metabolic Rate (RMR) - Individual education with Registered Dietitian - Fitness Performance Test - Fitness Center Membership - Supervised exercise sessions in the Center for Heart Disease Prevention if additional monitoring needed. - Fit Smart group education	Benefits Not Covered
TYPE OF SERVICE	**IN-NETWORK PROVIDERS (PPO Contracted Rates)**	**OUT-OF-NETWORK PROVIDERS**
GoStrong Diabetes Benefit Program	100%	Benefits Not Covered
	GoStrong **Participation Requirements:**	
	GoStrong Step 1	
	• Must have A1c of 6.4 or above or be recommended as a newly diagnosed diabetic • Coaching 1 x per week • Lifestyle Lab 1 x per week • Work out at the gym or on your own with a goal of 150 minutes or more per week • Personal Training 1 x per week • Biometrics and Labs @Beginning and End • RMR annually • Foot and Eye exam annually * • Physician visit quarterly • Nutritional and behavioral consultations - 2 • Duration: 3-6 months, maximum duration of 12 months for Step 1 and/or Step 2 combined	

	GoStrong Step 2
	• Must have A1c of 6.4 or above and have completed Step 1 or passed a test on knowledge of diabetes • Must be diagnosed with diabetes • Coaching 1 x per month • Lifestyle Lab 1 x per month • Work out at the gym or on your own with a goal of 150 minutes or more per week • Personal Training 2 x per month • Biometrics and Labs at the end of this program or every 6 months • RMR annually • Foot and Eye exam annually * • Physician visit quarterly • Nutritional and behavioral consultation - 1 • Duration: 3-6 months, maximum duration of 12 months for Step 1 and/or Step 2 combined
	GoStrong Step 3
	• Must have A1c 6.4 or above and be diagnosed with diabetes OR have completed Step 2 • Work out at the gym or on your own with a goal of 150 minutes or more per week • Biometrics and Labs (A1c and Lipids): if A1c is under 7.0, every 6 months; if A1c is 7.0 or above, quarterly • RMR annually • Foot and Eye exam annually * • Coach check-ins: if A1c is under 7.0, every 6 months; if A1c is 7.0 or above, quarterly • Peer group session: if A1c is under 7.0, as desired; if A1c is 7.0 or above, quarterly • Personal training: if A1c is under 7.0, 1 per quarter as desired; if A1c is 7.0 or above, quarterly • Physician visit: if A1c is under 7.0, annually; if A1c is 7.0 or above, quarterly • Nutritional and behavioral consultations – as desired • Duration: continuous
	GoStrong Step H
	• Must be diagnosed with diabetes and unable to join steps 1-3 due to enrollment timelines, or cannot continue with steps 1-3 due to illness, surgery, or other serious, but temporary health issues. • First-time enrollees must meet with a coach to begin intake process and join the Wellness Center.
	<u>GoStrong Member Benefits:</u>
	GoStrong Steps 1-3

	• Enhanced Rx Program for Diabetic Drugs
	  ○ $0 co-pay for Tier 1 Drugs
	  ○ 50% co-pay reduction for Tier 2 drugs
	• Free Diabetes Foot & Eye Exam*
	• Free Gym Membership
	• Free testing supplies
	• 6 visits with City of Savannah EAP Services
	• Members can access up to 4 hours each of nutrition and diabetes

	education • Free personal training • Free labs per program design
	GoStrong Step H Benefits
	• Enhanced Rx Program for Diabetic Drugs o $0 co-pay for Tier 1 Drugs o 50% co-pay reduction for Tier 2 drugs • Free Diabetes Foot & Eye Exam* • Free Gym Membership • Free testing supplies • 6 visits with City of Savannah EAP Services • Members can access up to 4 hours each of nutrition and diabetes education • Free personal training • Free labs
	Diabetes Management Program Through Quantum Health
	• Enhanced Rx Program for Diabetes Drugs o $0 co-pay for Tier 1 Drugs o 50% co-pay reduction for Tier 2 drugs o Free testing supplies • Free Diabetes Foot & Eye Exam* • Members can access up to 4 hours each of nutrition and diabetes education • Subsidized gym membership
***Foot exams must be performed by an in-network podiatrist to be considered for coverage.** ***Eye exams must be performed by an in-network ophthalmologist to be considered for coverage.**	

TYPE OF SERVICE	IN-NETWORK PROVIDERS (PPO Contracted Rates)	OUT-OF-NETWORK PROVIDERS
Nutritional and/or Diabetes Education **Contact St Joseph's/Candler Center for Disease Management** **836 East 65th St, Bldg. #4** **Phone: 912-819-6146**	100% 4 hours each of nutrition and diabetes education annually	Benefits Not Covered
Shape Down for Kids Program **Contact St Joseph's/Candler Wellness Center** **5353 Reynolds Street** **Phone: 912-819-8800**	100% 2-week program for children and teens age 6-12 years. A team of health professionals with expertise in pediatric obesity will work with the entire family to develop an exercise plan, behavior modification, improved self-esteem, stress management, and long-term follow up care. Children who are at the 85th percentile of their weight or above participate in specially designed age-appropriate exercise classes.	Benefits Not Covered

Prevent T2	100% Must be at least age 18, overweight (BMI >or= 25) and at high risk of developing type 2 diabetes and eligible by either: a physician's diagnosis and/or confirmatory blood test; or documentation of a combination of risk factors identified by the CDC. Contact the Employee Health Coordinator in the Human Resources Benefits Division at 912-651-6484.	Benefits Not Covered

CITY OF SAVANNAH WELLNESS PLAN – SAV4Health

The Plan is designed to encourage healthy lifestyle choices and committed to supporting employees who wish to take steps toward healthier lifestyles. As a benefit, the Plan rewards those efforts. Incentives are offered for completion of certain health-related activities as well as incorporates new programs to promote sustainable healthy lifestyle choices.

Employees who participate in the Plan will be given the opportunity to earn the **SAV4Health** premium incentive rate by:

1. Visiting your doctor for your annual check-up.
2. Getting your Biometric Screening at a city-sponsored screening event or with your doctor (PCP) as part of your annual check-up.
3. Completing your health questionnaire online or by calling your Care Coordinators.
4. Certifying you are tobacco free or ready to enroll in a tobacco cessation program according to your tobacco affidavit.

Employees will complete a tobacco affidavit certifying their tobacco status and will be given the opportunity to earn the **SAV4Health** premium incentive rate for the following plan year.

Employees hired July 1 – December 31 are exempt from the following requirements to earn the following SAV4Health Incentives: annual check-up, Biometric Screening and Completion of the health questionnaire.

Newly hired employees will complete a tobacco affidavit upon enrollment in the benefit plan.

If a tobacco user cannot complete a tobacco cessation program for medical reasons, a medical waiver form can be obtained from City of Savannah Human Resources Department, Benefits Division. The waiver form must be completed and signed by the employee and his/her physician. The form must be returned by the date stated on the waiver.

V. MEDICAL BENEFITS

A. Benefit Levels

In-Network Providers – If a Covered Person has incurred Covered Services rendered by an In-Network Provider, the Plan will pay the Coinsurance amount as shown in the Schedule of Medical Benefits subject to the Contracted Rate, except as provided by the outpatient dialysis provision (after satisfaction of the applicable Calendar Year Deductible).

Out-of-Network Providers – If a Covered Person has incurred Covered Services rendered by an Out-of-Network Provider, the Plan will pay the Coinsurance amount as shown in the Schedule of Medical Benefits subject to the Allowed Amount or Qualifying Payment Amount, as applicable, except as provided by the outpatient dialysis provision (after satisfaction of the applicable Calendar Year Deductible).

No Surprises Billing - Covered Services that are emergency services rendered by Out-of-Network Providers for "Emergency Care" as defined in the section titled "Definitions"; air ambulance services rendered by Out-of-Network Providers of air ambulance services; and non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, provided the Covered Person has not validly waived the applicability of the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA), will be paid at the In-Network Provider Deductible, Co-payment and Coinsurance levels, subject to the Qualifying Payment Amount.

When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's Out-of-Network level of benefits, subject to the Allowed Amount.

When services are rendered by an Out-of-Network Provider in any instance other than the reasons listed above, Covered Persons may be responsible for any amount above the Allowed Amount when services are rendered by an Out-of-Network Provider.

Traveling benefit – If a Covered Person is traveling out of country and requires medical treatment from an Out-of-Network Provider (excluding when a Covered Person traveled to such location for the primary purpose of obtaining medical services, drugs or supplies), benefits shall be payable at In-Network Provider Co-payment and Coinsurance levels

subject to the Allowed Amount or Qualifying Payment Amount, as applicable (after satisfaction of the applicable Calendar Year Deductible).

Deductible –With respect to a Covered Person, the Deductible for Covered Services rendered by an In-Network Provider or an Out-of-Network Provider in each Calendar Year shall be as shown in the Schedule of Medical Benefits. The Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the individual Deductible, claims will be paid for that individual. Otherwise, the entire family Deductible must be satisfied before claims will be paid for any family members. The family Deductible may be met by any combination of family members.

Single accident Deductible – If two or more Covered Persons in the same family are injured in a common accident, the Deductible applicable in the Calendar Year of the common accident for Covered Services related to that accident incurred by all family members shall be limited to a single per person Deductible for that Calendar Year.

The In-Network and Out-of-Network Deductibles are separate and do not co-accumulate. Eligible In-Network expenses which track toward the In-Network Deductible will not be credited toward satisfaction of the Out-of-Network Deductible and vice versa.

IMPORTANT NOTE:

Under the following circumstances, Out-of-Network Provider expenses will be covered at the In-Network Deductible, Coinsurance, and Out-of-Pocket levels:

- Services are not available within their assigned Network service area, such as ambulance and chiropractic care as well as specific physician specialties. It is recommended the Covered Person check with a Care Coordinator to verify non-availability of these services within the network.

- Services are not available within The Care Network Service area but are available at Mayo Clinic, Nemours Children's Health, or Children's Hospital of Georgia; however it is not in the best interest of the Covered Person to have services rendered at these facilities. This would include circumstances when traveling to Mayo Clinic, Nemours Children's Health, or Children's Hospital of Georgia is medically inadvisable or puts an undue financial burden on the Covered Person. It is recommended the Covered Person check with a Care Coordinator for approval based on their specific situation.

- For labs ordered by an In-Network Pprovider.

NOTE: Not all physicians practicing at an In-Network facility are in the network and claims from these providers may result in higher Out-of-Pocket expenses.

Some outpatient facilities operated by In-Network Providers may not be considered In-Network. For example, some outpatient surgical centers and rehabilitation centers owned

or operated by In-Network Physicians are not in the network. Be sure to check on the network status of these facilities before seeking care.

It is the Covered Persons's responsibility to confirm whether a specific provider is participating in the PPO Network. It is the Covered Person's choice as to which Provider to use.

Out-of-Pocket Maximum – The Out-of-Pocket Maximums are shown in the Schedule of Medical Benefits. The Family Plan contains both an individual Out-of-Pocket Maximum and a family Out-of-Pocket Maximum. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximum is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximum may be met by any combination of family members. The Out-of-Pocket Maximum excludes charges in excess of the Allowed Amount and any penalties for failure to follow Preadmission/Precertification Requirements.

The In-Network and Out-of-Network Out-of-Pocket Maximums are separate. Eligible In-Network expenses which track toward the In-Network Out-of-Pocket Maximum will not be credited toward satisfaction of the Out-of-Network Out-of-Pocket Maximum and vice versa.

Continuity of Care - In the event a Covered Person is a continuing care patient receiving a course of treatment from an In-Network Physician Provider or from a provider that otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the provider's failure to meet applicable quality standards or for fraud, the Covered Person shall have the following rights to continuation of care, if so elected, for a period ending 90 days later or when the Covered Person ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1) is undergoing a course of treatment for a serious and complex condition from a specific provider,
2) is undergoing a course of institutional or inpatient care from a specific provider,
3) is scheduled to undergo non-elective surgery from a specific provider, including receipt of postoperative care with respect to the surgery,
4) is pregnant and undergoing a course of treatment for the Pregnancy from a specific provider, or
5) is or was determined to be terminally ill and is receiving treatment for such illness from a specific provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred. However, the provider may be free to pursue the Covered Person for any amounts above the Plan's benefit amount.

B. Complex Case Management/Alternate Treatment Coverage

MyQHealth by Quantum Health's Care Coordination Process

INTRODUCTION

The Plan incorporates a "Care Coordination" process by MyQHealth which leverages resources including but not limited to your Employer, the Plan and the Third-Party Administrator, your provider and your community to help you best navigate the healthcare system. This process includes a staff of Care Coordinators who receive notifications regarding most healthcare services sought by Covered Persons, and coordinate activities and information flow between the providers.

Care Coordination is intended to help Covered Persons obtain quality healthcare and services in the most appropriate setting, help reduce unnecessary medical costs, and ensure early identification of Covered Persons with complex medical conditions. The Care Coordinators are available to Covered Persons and their providers for information, assistance, and guidance, and can be reached toll-free by calling:

Care Coordinators: 1- 866-360-7926

It is important to note that clinical reviews are done to determine Plan coverage and are conducted by the clinical staff of MyQHealth.

CARE COORDINATION REQUIREMENTS

In order to receive the highest benefits available in the Plan, Covered Persons must follow the Care Coordination process outlined in this section, as well as other provisions in the Plan. In some cases, failure to follow this process can result in significant benefit reductions, penalties or even loss of benefits for specific services.

The Care Coordination process generally includes:

- Use of in-network providers
- Designating a Coordinating Provider (PCP)
- The Care Coordination Process and Utilization Management
  - Preauthorization and Clinical Review
  - Concurrent Utilization Review
  - Personal Care Guide Management

Use of In-Network Providers

The Plan offers a broad network of providers and provides the highest level of benefits when Covered Persons utilize "In-Network" providers. These networks will be indicated on your Plan identification card. **Services provided by Out-of-Network providers will not be eligible for the highest benefits**. Specific benefit levels are shown in the Schedule of Benefits.

Designated Coordinating Provider

All Covered Persons are asked to designate a coordinating Primary Care Provider (PCP) for each covered member of their family. While such designation is not mandatory, it is strongly recommended. **To ensure highest level of benefits, and the best coordination of your care, all Covered Persons are encouraged to designate an In-Network Primary Care Provider (PCP) to be their coordinating Provider.** The Care Coordination process generally begins with the coordinating Provider who maintains a relationship with the Covered Person, provides general healthcare evaluation, guidance, and management.

Covered Persons are encouraged to begin all healthcare events or inquiries with a call or visit to their designated PCP who will guide Covered Persons as appropriate. In addition to providing Care Coordination and submitting preauthorization requests, the PCP may also receive notices regarding healthcare services that their designated patients receive under the Plan. This allows the PCP to provide ongoing healthcare guidance.

If you have trouble obtaining access to a PCP, the Care Coordinators will be able to assist you by providing a list of in-network PCPs. Please contact the Care Coordinators by calling:

Care Coordinators: 1- 866-360-7926

Utilization Management

Preauthorization and Clinical Review

To be covered at the highest level of benefit and to ensure complete Care Coordination, the Plan requires that certain care, services, and procedures be preauthorized before they are provided. Preauthorization requests are submitted to the Care Coordinators by a designated PCP, other PCP, specialty provider or other healthcare provider. Your Plan identification card includes instructions and the phone number for them to call. Depending on the request, the Care Coordinators may contact the requesting provider to obtain additional clinical information to support the request for the preauthorization and to ensure that the care, service and/or procedure meet Plan and nationally accepted medical criteria. If a pre-authorization request does not meet Plan and nationally accepted medical criteria, the Covered Person and healthcare provider will be notified, and the Care Coordinators will assist in redirecting care if appropriate.

The following care, services and procedures are subject to preauthorization:

- Inpatient and Skilled Nursing Facility Admissions
- Outpatient Surgeries
- MRI/MRA and PET scans
- Oncology Care and Services (chemotherapy, radiation therapy, clinical trials)
- Genetic Testing
- Dialysis
- Organ, Tissue, and Bone Marrow Transplants

- Home Health Care
- Hospice Care
- Durable Medical Equipment - all rentals and any purchase over $1500.
- Partial Hospitalization and Intensive Outpatient for Mental Health/Substance Use Disorders

All preauthorizations and clinical review services are conducted by MyQHealth. Care Coordinators will assist Covered Persons in understanding what services require preauthorization.

PENALTIES FOR NOT OBTAINING PREAUTHORIZATION

A Non-notification Penalty is the amount you must pay if preauthorization is not requested for a service prior to receiving the service. Covered expenses will be reduced if a Covered Person receives services but did not obtain the required preauthorization for:

- Inpatient and Skilled Nursing Facility Admissions ($500 PENALTY)
- Outpatient Surgeries
- MRI/MRA and PET scans
- Oncology Care and Services (chemotherapy, radiation therapy, clinical trials)
- Genetic Testing
- Dialysis
- Organ, Tissue, and Bone Marrow Transplants
- Home Health Care
- Hospice Care
- Durable Medical Equipment - all rentals and any purchase over $1500.
- Partial Hospitalization and Intensive Outpatient for Mental Health/Substance Use Disorders

For preauthorization, Providers should call the number listed on the Plan identification card.

Concurrent Utilization Review

MyQHealth will regularly monitor an inpatient hospital stay, other institutional admission, or ongoing course of care for any Covered Person, and evaluate the appropriateness of the level of care and if the stay is meeting medical necessity. If necessary, they will examine the possible use of alternate levels of care or facilities. MyQHealth will communicate regularly with attending providers, the utilization management staff and/or discharge planners of such facilities, and the Covered Person and/or family to monitor the Covered Person's progress and anticipate and initiate planning for discharge needs. Such concurrent review, and authorization for Plan coverage of inpatient days, is conducted in accordance with the utilization criteria adopted by the Plan, MyQHealth, and nationally accepted medical criteria.

Personal Care Guide Management

MyQHealth utilizes a primary nurse model for chronic condition as well as acute condition management. This enhanced approach provides one nurse to address clinical needs for all chronic and acute issues. The Personal Care Guide (PCG) nurse will consult with the Covered Person, their family (if requested), the attending Physician, and other members of the Covered Person's treatment team to assist in facilitating/implementing proactive plans of care which provide the most appropriate health care and services in a timely, efficient and cost-effective manner. They assist with benefits, incidental health care issues, becoming healthier, finding resources or an unexpected healthcare journey.

During outreach, the Personal Care Guide will touch on the Covered Person's treatment and perform a physical assessment, perform a medication reconciliation to ensure there are no duplications or interactions, perform a depression screening with subsequent referrals to EAP or in-network providers, as well as focus on the physical and emotional needs of the Covered Person.

The Personal Care Guide will look at the Covered Person's psychosocial needs and social determinants of health. In addition to the depression screening, they will evaluate the Covered Person's financial issues, knowledge deficits, as well as any cultural barriers that may exist. Conversations with the Covered Person would occur at least monthly, if not more frequently, and continue until the Covered Person's health goals and needs are met.

The primary Personal Care Guide nurse will align with the Covered Person and be the single point of contact them, and their family and caregivers, and providers.

The primary Personal Care Guide nurse will:

- Provide comprehensive benefit education/utilization support
- Drive PCP designation and steerage to in-network providers
- Encourage provider involvement
- Deliver pre-certification assistance
- Perform pre-admission, pre-discharge, and post-discharge engagement
- Coordinate for utilization review and discharge planning
- Identify gaps in care and alleviate clinical, financial, and humanistic barriers
- Coordinate second opinions, drive utilization to other third-party vendor tools, and introduce community resources
- Perform behavioral health screening
- Our primary nurse model has three foundational drivers for the changes:
- Humanistic: to help members with acute and chronic needs by assigning a single nurse to the Covered Person and their family as well as a heightened attention to psychosocial issues that can negatively affect health, quality of life and financial outcomes.
- Clinical: identify and prioritize members in need of clinical outreach. Improve adherence to quality measures for preventive health and management of chronic conditions.

- Financial: identify and outreach to members at risk for future high costs while encouraging preventive care and chronic condition management to improve health and reduce costs.

GENERAL PROVISIONS FOR CARE COORDINATION

Authorized Representative

The Covered Person is ultimately responsible for ensuring that all preauthorizations are approved and in place prior to the time of service to receive the highest level of benefits. However, in most cases, the actual preauthorization process will be executed by the Covered Person's Primary Care Provider or other providers. By subscribing to this Plan, the Covered Person authorizes the Plan and its designated service providers (including MyQHealth and the Third Party Administrator, and others) to accept healthcare providers or those providers who otherwise have knowledge of the Covered Person's medical condition, as their authorized representative in matters of Care Coordination, including preauthorization requests. Communications with and notifications to such healthcare providers shall be considered as notification to the Covered Person.

Time of Notice

The preauthorization request should be made to the Care Coordinators within the following timeframe:

- At least **three business days,** before a scheduled (elective) Inpatient admission
- By the next business day after, an emergency Hospital admission
- Upon being identified as a potential organ or tissue transplant recipient
- At least **three business days** before receiving any other services requiring preauthorization

For preauthorization, Providers should call the number listed on the Plan identification card.

Special Note: The Covered Person will not be penalized for failure to obtain preauthorization if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who receive care on this basis must contact the Care Coordinators as soon as possible within 24 hours of the first business day after receiving care or Hospital admittance. Care Coordinators will then coordinate with MyQHealth Utilization Management to review services provided within 48 hours of being contacted.

"Emergency" Admissions and procedures

Any Inpatient admission or Outpatient procedure that has not been previously scheduled and cannot be delayed without harming the Covered Person's health is considered an emergency for purposes of the Utilization Management notification.

Maternity Admissions

A notice regarding admissions for childbirth should be submitted to the Care Coordinators in advance, preferably 30 days prior to expected delivery. The Plan and the Care Coordination process complies with all state and federal regulations regarding Utilization Management for maternity admissions. The Plan will not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require preauthorization or authorization for prescribing a length of stay not in excess of these periods. If the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or her newborn earlier than the applicable 48 or 96 hours, the Plan will only consider benefits for the actual length of the stay. The Plan will not set benefit levels or out-of-pocket costs so that any later portion of the 48 or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Care Coordination is Not a Guarantee of Payment of Benefits

The Care Coordination process does not provide a guarantee of payment of benefits. Approvals of preauthorizations for procedures, hospitalizations and other services indicate that the medical condition, services, and care settings meet the utilization criteria established by the Plan. The Care Coordination approvals do not indicate that the service is a covered benefit, that the Covered Person is eligible for such benefits, or that other benefit conditions such as co-pay, deductible, co-insurance, or maximums have been satisfied. Final determinations regarding coverage and eligibility for benefits are made by the Plan.

Result of Not Following the Coordinated Process of Care

Failure to comply with the Care Coordination Process of Care may result in reduction or loss in benefits. The Penalties for not obtaining preauthorization section specifies applicable penalties. Charges you must pay due to any penalty for failure to follow the Care Coordination Process do not count toward satisfying any deductible, co-insurance, or out-of-pocket limits of the Plan.

Appeal of Care Coordination Determinations

Covered Persons have certain appeal rights regarding adverse determinations in the Care Coordination process, including reduction of benefits and penalties. The appeal process is detailed in the Claims and Appeal Procedures section within this document.

If a Covered Person’s condition is, or is expected to become, serious and complex in nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified organization. The purpose of the case management service is to help plan necessary, quality care in the most cost-effective manner with the approval and cooperation of the Covered Person, family and attending Physician(s). This is a voluntary service to help manage both care and cost of a potentially high-risk or long term medical condition, and neither Covered Persons nor treating Physicians are required to participate in complex case management.

If a case is identified as appropriate for complex case management, then the case management organization will contact the treating Physician(s) and Covered Person to develop and implement a mutually agreeable treatment plan. If either the attending Physician or the Covered Person does not wish to follow the treatment plan, benefits will continue to be paid as stated in the Plan.

If the Physician(s) and Covered Person agree to the treatment plan, in some cases services not normally covered by the Plan may be eligible for coverage. If it appears that the most appropriate and cost-effective care will be rendered in a setting or manner not usually covered under the terms of the Plan, such care may be covered under the auspices of a complex case management treatment plan. In such cases, all Medically Necessary services included in the approved treatment plan will be covered under the terms of the Plan. However, the coverage of services under a complex case management plan that are not otherwise covered under this Plan does not set any precedent or create any future liability for coverage of such services with respect to either the Covered Person who is the subject of the plan or any other Covered Persons. Benefits provided under this section are subject to all other Plan provisions.

C. Disease Management and Prevention Programs

Disease-based intervention programs administered by a City approved program. Participation is voluntary. The Plan covers the cost of the program listed in the Schedule of Benefits, and only when the Covered Person adheres to the compliance agreement of the program.

These programs include:

(1) Weigh to GO Programs

These programs include education and counseling to assist with the achievement of long-term weight control. Levels 2, 3, and the Weight Management Maintenance Program are covered under the Plan. Removal of excess skin due to weight loss will be covered for members who participate in and are compliant in the Weight Management Program. Weigh to GO can assist members with losing weight, provide education on how to improve health through proper nutrition and exercise, and assist in meeting individual personal health, fitness and weight loss goals. This program is covered under The Plan as long as requirements continue to be met by the participant. Participant requirements are evaluated on a quarterly basis. If a participant fails to meet program requirements for any quarter, the Plan will not cover the cost of the program for four quarters following the failure to meet Plan requirements. The program will communicate with the treating physician during the member's active participation. Lab work must be completed and processed at St. Joseph's/Candler labs. A copy of lab results will be sent to the member's physician. To enroll in the program, contact St. Joseph's/Candler Wellness Center, 5353 Reynolds Street Phone: 912-819-8800 to schedule an Orientation visit.

(2) Diabetes Education Services

Educational services are offered to individuals with diabetes who are newly diagnosed, those who have had a change in their diabetic condition, juvenile onset and gestational diabetes. The education series will cover up to 4 hours of individual instruction through an ADA certified provider. The education will include a diabetes overview, and education regarding nutrition, exercise and activity, instruction regarding medications, monitoring and use of results, prevention, detection and treatment of serious complications. When participants require more long-term monitoring, the Go Strong program is recommended. Diabetes Education Services does not include medications, testing supplies or other benefits associated with the GoStrong Program. Contact St Joseph's/Candler Center for Disease Management, 836 East 65th St, Bldg. #4, Phone: 912-819-6146

(3) GoStrong Program

The GoStrong Program is designed to teach individuals with diabetes to self-manage the disease. In order to maintain optimal control of this condition, individuals must be directly involved in the day-today management of the disease. This diabetes engagement program assists individuals with diabetes to attain the knowledge and skills to make informed choices, to facilitate independent behavior changes and, ultimately, to reduce the risk of complications. The program is designed for all patients with differing risk levels of diabetes. Program components include exercise, personal fitness training, nutrition therapy, diabetes management education including up to four (4) hours nutritional counseling, glucose monitoring equipment and testing supplies, comprehensive lab work, foot examination and eye exam. There is no annual co-payment requirement. Active participants in the program receive enhanced prescription drug benefits including $0 co-pay for Tier 1 and 50% reduction in co-pay for Tier 2 for medications related to diabetes treatment, as well as other benefits as described in the Schedule of Benefits.

(4) Nutritional Counseling

Services by a registered dietitian will be covered up to 4 hours of individual counseling. **Contact** St Joseph's/Candler Center for Disease Management, 836 East 56th Street, Phone 912-819-6146

(5) Shape Down Program. A Weight Loss Program for Kids and Teens

A nationally recognized 2-week program for children and teens age 6-12 years. A team of health professionals with expertise in pediatric obesity will work with children and their families to develop an exercise plan, behavior modification, improved self-esteem, stress management, and long-term follow up care. Children must be in the 85th percentile or above in weight. Children participate in specially

designed age-appropriate exercise classes. Contact St Joseph's/Candler Wellness Center, 5353 Reynolds Street Phone: 912-819-8800.

(6) Prevent T2

Designed to enable adults to make lifestyle changes improving overall health and reducing risk of developing type 2 diabetes. In order to qualify for the Prevent T2 Program, you must be overweight (BMI>25) and at high risk for developing type 2 diabetes or have been diagnosed with pre-diabetes. In a classroom setting, a trained lifestyle coach helps you change your lifestyle by learning about healthy eating, physical activity and other behavior changes over the course of 16 one-hour sessions. After the initial 16 core sessions, participants meet monthly for maintenance. Contact Employee Health Coordinator in the Human Resources Benefits Division at 912-651-6484.

D. Covered Services

This section contains detailed information on the benefits covered under this Plan. Covered Services must be prescribed by a Physician and incurred for medical treatment of an Illness or Injury. Covered Services may be subject to a Calendar Year Deductible, Coinsurance, Co-payments and other limits as shown in the Schedule of Medical Benefits for the following:

(1) Prescription Drugs

Expenses for covered prescription drugs and medicines, including U.S. Food and Drug Administration (FDA) approved contraceptive medications and devices, will be covered as described in the section titled "Schedule of Medical Benefits" through retail pharmacies and the Prescription Benefit Manager's mail order program.

The benefits are payable for Medically Necessary prescription drugs ordered in writing by a Physician for treatment of a Covered Person. Certain prescribed medications (or the prescribed quantity of a drug) require "prior authorization" before Covered Persons may fill their prescriptions. Some medications require prior authorization as a safeguard to ensure the prescribed medication is safe, medically effective, and the most appropriate way to treat a Covered Person's condition. In some instances, if necessary, a Physician will ask for a clinical review, which will help determine whether the prescribed prescription is approved or denied under the Plan.

The presence of a drug on the Prescription Benefit Manager's formulary list does not guarantee coverage. The drugs listed on the Prescription Benefit Manager's formulary are subject to change. To find out if a medication is covered under the Plan, Covered Persons should contact the Prescription Benefit Manager at the phone number list on the back of his/her ID card for the most current formulary information.

<u>Prescription drug charges not covered, including but not limited to</u>:

(a) Drugs dispensed by any person not licensed to dispense drugs;

(b) Administration of drugs;

(c) Drugs labeled "Caution Limited by Federal Law for Investigational Use";

(d) Drugs administered and consumed at the time and place of the prescription issue;

(e) Non-legend drugs other than insulin and tobacco cessation products;

(f) Therapeutic devices or appliances, support garments and other non-medical substances;

(g) Investigational or experimental drugs, including compounded medications for non-FDA-approved use; and

(h) Prescriptions which an eligible person is entitled to receive without charge from any Worker's Compensation laws, or any municipal, state or federal program.

(2) Preventive Care

The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Specific services may be covered based on the recommended frequency, age and gender. For additional detail about the coverage levels, please go to www.HealthCare.gov.

(a) **Routine physicals

Routine adult physical examinations including all related charges and tests billed at the time of visit, including, but not limited to x-rays, laboratory and clinical tests and routine immunizations. Covered Services include, but are not limited to those listed at http://www.healthcare.gov/what-are-my-preventive-care-benefits/

(b) **Routine Well Child Care

Routine Well Child Care including all charges billed at the time of visit, including, but not limited to fluoride and fluoride varnish to age 6, physical examinations, history, sensory screening and neuropsychiatric evaluation and appropriate immunizations. Covered Services include, but are not limited to those listed at http://www.healthcare.gov/what-are-my-preventive-care-benefits/

(c) **Women's Preventive Services

Services include, but are not limited to, gestational diabetes screenings, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, human immunodeficiency virus (HIV) and domestic violence screenings and counseling. Covered Services include, but are not limited to those listed at http://www.healthcare.gov/what-are-my-preventive-care-benefits/

(i) Breastfeeding support, supplies and counseling by a trained provider during pregnancy and/or in the postpartum period and costs for renting/purchasing breastfeeding equipment; coverage for breast pumps, includes Hospital grade, electric, or manual;

(ii) Contraception and contraceptive counseling including all FDA approved prescription contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

(iii) Well-woman visits to obtain recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care; services are provided annually or as recommended

(d) **Routine gynecological/obstetrical care

Includes preconception and prenatal services; ovarian cancer screening; cervical cancer screening, including Pap smear

(e) **Breast cancer screening

Includes routine mammograms, counseling and BRCA testing for genetic susceptibility to breast cancer, and chemoprevention counseling for women at high risk for breast cancer and low risk for adverse effects of chemoprevention

(f) **Routine lab, x-rays and clinical tests

(g) **Routine colorectal cancer screening

Includes fecal occult screening, sigmoidoscopy and colonoscopy

(h) ** Lung cancer screening

Includes use of low dose computed tomography (LDCT) for adults age 55 and older who have a 30 pack per year smoking history and currently smoke or have quit within the past 15 years

(i) **Nutritional counseling

(j) **Smoking cessation counseling and intervention

Includes smoking cessation clinics and programs. Tobacco cessation products are available under the Prescription Drug Program

In order to assist employees in their efforts to be non-tobacco user, the Plan will sponsor cessation initiative at no cost to the employee. The Plan approved program is as follows:

Care Coordinators by Quantum Health Telephonic Coaching
Care Coordinators by Quantum Health offers a telephone-based coaching program to help employees quit tobacco use. Coaches perform an initial assessment and then develop a customized quit plan to help the member toward a goal of being tobacco-free. Care Coordinators by Quantum Health Tobacco Cessation Coaches are available during the hours of 8am to 8pm. This program requires 5 coaching calls for compliance. Contact your Care Coordinators at (866) 360-7926 for more information and to sign up for this program.

(k) Routine prostate exam

Includes Prostate-Specific Antigen (PSA) screening

(l) **Abdominal aortic aneurysm screening

(m) **Bone density screening

(3) Vision Care

(a) Vision eyewear for special conditions:

(i) Non-routine eye wear following surgery, initial purchase (lenses, frames, and contact lenses)

(ii) Contact lenses needed to treat keratoconus including the fitting of these contact lenses

(iii) Intraocular lenses implanted after corneal transplant, cataract surgery or other covered eye surgery when the natural eye lens is replaced

(4) Physician Services

(a) Allergy testing and treatment, including preparation of serum and injections

(b) Anesthesia (Inpatient/Outpatient)

(c) Chiropractic services from a licensed provider

(d) Maternity

Includes delivery, prenatal, and postpartum care of mother and fetus. Amniocentesis is included for women age thirty-five (35) and older.

(e) Physician Hospital visits

Medical diagnosis, care and/or treatment provided by a doctor or legally licensed Physician including Hospital inpatient care, Hospital outpatient visits/exams and clinic care

(f) Physician office visits

Medical diagnosis, care and/or treatment provided by a doctor or legally licensed Physician including office visits and home visits

(g) Second surgical opinion and, in some instances, a third opinion as follows:

Fees of a legally qualified Physician for a second surgical consultation when non-emergency or elective surgery is recommended by the Covered Person’s attending Physician. The Physician rendering the second opinion regarding the Medical Necessity of such surgery must be qualified to

render such a service, either through experience, specialization training, education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery; and

Fees of a legally qualified Physician for a third consultation, if the second opinion obtained does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who provided the second opinion or with the Physician who will be performing the actual surgery.

(h) Surgery (Inpatient/Outpatient/Office)

Physician or surgeon charges for a surgical operation and for the administration of anesthesia

If two or more surgical procedures are performed at one time through the same incision in the same operative field, the maximum allowable amount for the surgery will be as follows:

(i) For In-Network Providers: the Contracted Rate for the primary procedure and the greater of 50% of such Contracted Rate or the amount specified in the In-Network Provider's contract for the secondary or lesser procedure(s).

(ii) For Out-of-Network Providers: the Allowed Amount or Qualifying Payment Amount, as applicable, for the major procedure and 50% of the Allowed Amount or Qualifying Payment Amount, as applicable, for the secondary or lesser procedure(s).

No additional benefit will be paid under this Plan for incidental surgery done at the same time and under the same anesthetic as another surgery.

The Plan will also pay for a surgical assistant when the nature of the procedure is such that the services of an assistant Physician are Medically Necessary.

(5) Hospital Services – Inpatient

(a) Hospital room & board

Hospital room and board for a semiprivate room, intensive care unit, cardiac care unit or burn care unit, but excluding charges for a private room which are in excess of the Hospital's semiprivate room rate. Charges made by a Hospital for a private room when: i) determined to be Medically Necessary, ii) a semi-private room is not available; or iii) the Hospital only has private rooms will be allowed at the private room rate with no reduction. If a semi-private room is available and the Covered

Person chooses a private room, charges for a private room which are in excess of the Hospital's semi-private room rate will be excluded or, if the semi-private rate is not available, reduced by 20%

(b) Maternity services

Inpatient care for the mother and/or newborn child will be provided for a minimum of 48 hours following a vaginal delivery, or a minimum of 96 hours following a cesarean section. However, the mother's or newborn's attending Physician, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

No authorization from the Plan need be sought by the attending Physician for prescribing a length of inpatient stay for the mother or newborn not in excess of 48 hours (or 96 hours, for a cesarean section). The 48- or 96-hour limit may be exceeded with precertification in cases of Medical Necessity.

(c) Birthing Center

Birthing Center or freestanding health clinic services, with benefits limited to the amount that would have been paid if the Covered Person were in a Hospital

(d) Newborn care

Routine nursery care (including circumcision and Physician's visits) while confined for either 48 hours following a vaginal delivery, or a minimum of 96 hours following a cesarean section, even though no Illness or Injury exists

(e) Mastectomy

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

(i) All stages of reconstruction of the breast on which the mastectomy was performed;

(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(iii) Prostheses; and

(iv) Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan.

(f) Organ transplants – including bone marrow and stem cell transplants

Transplant Benefit Period: Covered transplant expenses will accumulate during a Transplant Benefit Period and will be charged toward the Transplant Benefit Period maximums, if any, shown in the Schedule of Medical Benefits. The term "Transplant Benefit Period" means the period which begins on the date of the initial evaluation and ends on the date which is twelve (12) consecutive months following the date of the transplant. If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant.

Covered transplant expenses: Covered Services which are Medically Necessary and appropriate to the transplant include:

(i) Evaluation, screening, and candidacy determination process;

(ii) Organ transplantation;

(iii) Organ procurement as follows:

Organ procurement from a non-living donor will be covered for costs involved in removing, preserving and transporting the organ;

Organ procurement from a living donor will be covered for the costs involved in screening the potential donor, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow-up care as described below;

If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of reinfusion. The harvesting of the marrow need not be performed within the Transplant Benefit Period.

If the donor is covered under the Plan, eligible charges will be covered.

If the recipient is covered under the Plan, but the donor is not, the Plan will provide coverage to both the recipient and donor as long as similar benefits are not available to the donor from other coverage sources.

(iv) Follow-up care, including immuno-suppressant therapy

Transportation: Transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two (2) other individuals.

Re-transplantation: Re-transplantation will be covered up to two (2) re-transplants, for a total of three (3) transplants per person, per lifetime. Each transplant and re-transplant will have a new Transplant Benefit Period.

(g) Charges for cosmetic purposes or for cosmetic surgery are covered only if due solely to:

(i) Bodily Injury, providing that coverage is in effect at the time treatment occurs;

(ii) Birth defect of a Covered Person, provided coverage is in effect at the time treatment occurs; or

(iii) Surgical removal of diseased tissue as a result of an Illness. Covered Persons electing breast reconstruction, following a mastectomy, are also covered for reconstruction of the other breast to produce symmetrical appearance, and coverage for prostheses and physical complications of all stages of a mastectomy. The reconstruction procedure will be performed in a manner determined between the Physician and patient.

(6) Surgical Facility and Supplies

(7) Miscellaneous Hospital Charges

(a) Medically Necessary supplies and services including x-ray and laboratory charges and charges for anesthetics and administration thereof

(b) Drugs and medicines charged by a Hospital which are obtained through written prescription by a Physician

(c) Administration of infusions and transfusions, including the cost of unreplaced blood and blood plasma or autologous blood and blood plasma. Expenses for storage of autologous blood or blood plasma will not be covered

(d) Inpatient respiratory, physical, occupational, inhalation, speech and cardiac rehabilitation therapy

(8) Hospital Services – Outpatient

(a) Clinic services

(b) Emergency room services

(c) Outpatient department

(d) Outpatient surgery in Hospital, ambulatory center or other properly licensed facility

(e) Preadmission testing

Preadmission tests on an outpatient basis for a scheduled Hospital admission or surgery

(f) Urgent care facility/walk-in clinic

Emergency treatment center, walk-in medical clinic or ambulatory clinic (including clinics located at a Hospital)

(9) Mental Health/Substance Use Disorders

Inpatient confinement (including confinement in a residential treatment facility) or Partial Hospitalization/Intensive Outpatient Treatment for the treatment of a mental Illness in a licensed general Hospital, in a mental Hospital under the direction and supervision of the Department of Mental Health, or in a private mental Hospital licensed by the Department of Mental Health, or confinement or Partial Hospitalization/Intensive Outpatient Treatment in a public or private substance use disorder facility.

Outpatient treatment of Mental Health Disorders and outpatient treatment of substance use disorders on an outpatient basis provided services, including methadone maintenance and treatment, are furnished by a:

(a) Comprehensive health service organization;

(b) Licensed or accredited Hospital;

(c) Community mental health center, or other mental health clinic or day care center which furnishes mental health services, subject to the approval of the Department of Mental Health;

(d) Licensed detoxification facility;

(e) Licensed social worker;

(f) Psychologist; or

(g) Psychiatrist

(10) Other Services and Supplies

(a) Ambulance services:

(i) To the nearest Hospital or medical facility which is equipped to provide the service required;

(ii) When Medically Necessary, from a Hospital; or

(iii) For an air ambulance or rail transportation to the nearest medical facility equipped to provide care when failure to do so may seriously jeopardize the health or risk the life of the patient.

(b) Autism spectrum disorders treatment

Autism spectrum disorders treatment including habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, or therapeutic care. Covered Services include, but are not limited to, Applied Behavior Analysis (ABA); occupational, physical and speech therapies; and social work services

(c) Bariatric surgery

Clinical requirements for bariatric surgery under the Plan:

- Treatment indicated by any ONE of the following:
  - Patient has a BMI exceeding 40 kg/m^2.
  - Patient's BMI is greater than 35 kg/m^2 and two or more clinically serious conditions exist (e.g., obesity hypoventilation, sleep apnea, diabetes, hypertension (high blood pressure), cardiomyopathy, musculoskeletal dysfunction, joint replacement, GERD, hypertriglyceridemia or hypercholesteremia, back pain, urinary incontinence, renal failure, arthritis.)
- Surgical intervention indicated because patient has met all the following criterion:
  - Patient is well-informed and motivated and has been unsuccessful in previous non-surgical weight loss attempts.
  - No thyroid disorder (excluding thyroid problems currently being successfully treated) found by your physician [e.g., an endocrine (hormone) disorder].
  - Must have obtained full growth and be over the age of 18 years.
  - Documentation of a pre-operative psychological evaluation by a

licensed clinical psychologist or psychiatrist within the last 90 days to determine if the patient has the emotional stability to follow through with the medical regimen that must accompany the surgery.

- Participation in a physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who supervised the member's participation. The St Joseph's Candler Level 3 Weigh to GO program is plan sponsored and required for members seeking bariatric surgery. The program is to be completed 6 months prior to bariatric surgery and upon physician release 6 months post- bariatric surgery. (See "Weigh to GO" under "Disease Management and Prevention Programs" in this section for more program details.) **For covered spouses, dependents and retirees who reside outside of the Care Network service area, physician-supervised pre and post-surgery** nutrition and exercise program must be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program must be supervised by the surgeon who will perform the surgery or by another treating physician. Note: A physician's summary letter is not enough documentation. Documentation must include medical records of the physician's concurrent assessment of the patient's progress throughout the course of the nutrition and exercise program. For those who participate in a physician-administered nutrition and exercise program, program records documenting the participants participation and progress may substitute for physician medical records. Nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists, with a substantial face-to-face component (must not be entirely remote); and Nutrition and exercise program(s) must be for a cumulative total of 6 months or longer in duration and occur within the 12 month period prior to the scheduled surgical intervention.

Additional requirements for bariatric surgery under the Plan:

- Evaluation by physician;
- Behavior modification program supervised by a qualified professional;
- Psychological evaluation;
- Documentation in the member's medical record of active participation and compliance with the multidisciplinary surgical preparatory regimen at each visit. A physician's summary letter, without evidence of concurrent oversight is not enough documentation. Documentation should include medical records of the physician's initial assessment of the member, and the

physician's assessment of the member at the completion of the multidisciplinary surgical preparatory regimen;

- Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise therapist or other qualified professional;
- Documentation of commitment by primary care physician to follow up care and plan of care to include schedule of follow up visits; and
- Other information as requested by Care Coordinators.

Contraindications to bariatric surgery:
Requests for bariatric surgery will be denied if any one or more of the following conditions are present:

- Untreated major depression of psychosis
- Binge-eating disorders
- Current drug or alcohol abuse
- Severe cardiac disease with prohibitive anesthetic risks
- Severe coagulopathy
- Inability to comply with nutritional requirements including life-long vitamin replacement

Bariatric Surgery requires pre-certification through the Care Coordinators by Quantum Health**.**

The patient or their physician should contact ***Care Coordinators by Quantum Health*** at 1-866-360-7926.

(d) Breast reduction surgery when deemed to be Medically Necessary

(e) Cardiac rehabilitation

Expenses for Cardiac Rehabilitation Program (limited to Phase I and Phase II only) provided such treatment is recommended by the attending Physician. Phase I consists of acute inpatient hospitalization, whether for heart attack or heart surgery, highly supervised with a tailored exercise program with continuous monitoring during exercise. Phase II consists of supervised outpatient treatment for Covered Persons who have left the Hospital but still need a certain degree of supervised physical therapy and monitoring during exercise. Phase II services are usually tailored to meet the Covered Person's individual need. Benefits are not payable for Phase III which consists of outpatient services without supervision. The Phase III program is developed for patients who are well enough to continue exercising on their own, monitoring their own progress.

(f) Chemotherapy and radiation therapy

(g) Clinical Trials - Routine services for Approved Clinical Trials

Routine costs for items and services furnished in connection with participation in Approved Clinical Trials are covered at the same level as the same services provided outside Approved Clinical Trials, including Hospital visits, imaging and laboratory tests if:

(i) The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate, or

(ii) The participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate, and

(iii) These services are Covered Services under the Plan

(h) Cochlear implants

(i) Dental/oral services (limited)

The following dental procedures including related Hospital expenses, (when Hospital expenses are deemed to be Medically Necessary) will be covered the same as any other Illness:

(i) Treatment of an Injury to a sound natural tooth, other than from eating or chewing, or treatment of an Injury to the jaw. Surgery needed to correct Injuries to the jaw, cheek, lips, tongue, floor and roof of the mouth;

(ii) Excision of a tumor, cyst, or foreign body of the oral cavity and related anesthesia;

(iii) Biopsies of the oral cavity and related anesthesia; and

(iv) Removal of bony impacted teeth, and related anesthesia.

Note: If a Covered Person has a serious medical condition that requires hospitalization or treatment in an Ambulatory Surgical Center for dental services other than those listed above, Plan benefits are payable only for the Hospital or Ambulatory Surgical Center and anesthesiologist charges, but not for the dentist's charges.

(j) Diabetes self-management training and education

(k) Diagnostic imaging (MRI, CT scan, PET scan)

(l) Diagnostic x-ray and laboratory

X-ray, microscopic tests, laboratory tests, including electro-cardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

(m) Dialysis/Hemodialysis – Outpatient

The following describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

Reasons for the Dialysis Program.

The Dialysis Program has been established This for the following reasons:

(1) the concentration of dialysis providers in the market in which Plan reside may allow such providers to exercise control over prices for dialysis-related products and services,

(2) the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,

(3) evidence of (i) significant inflation of the prices charged to Plan by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of non-governmental and non-commercial plans, such as the Plan, by dialysis providers as profit centers, and

(4) the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the interests of Plan members, such as subsidies for other plans and discriminatory profit-taking.

Dialysis Program Components.

The components of the Dialysis Program are as follows:

(1) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and

services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

(2) Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after January 1, 2022, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.

(3) Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:

(i) Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

(ii) Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

(4) In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the member, to the following payment limitations, under the following conditions:

(i) Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

(ii) Maximum Benefit. Except as provided in the preceding subsection or where an acceptable provider agreement is entered into, the maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

(iii) Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

(iv) Additional Information related to Value of Dialysis-Related Services and Supplies. The member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

(vi) All charges must be billed by a provider in accordance with generally accepted industry standards.

(5) Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

(6) Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of this Section, to make determinations regarding issues which relate to eligibility for benefits under this Section, to decide disputes which may arise relative to a Plan's rights under this Section, and to decide questions of interpretation of this Section and those of fact relating to the application of this Section. The decisions of the Plan Administrator will be final and binding on all interested parties.

(7) Provider Acceptance. A provider that accepts the payment from the Plan under this Section will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Plan member, and (ii) it shall not "balance bill" a Plan member for any amount billed but not paid by the Plan.

(n) Durable medical equipment

Rental or purchase (whichever is less) of durable medical equipment to aid impaired functions, including but not limited to: wheelchairs, standard Hospital-type bed, mechanical respirator, CPAP machines, bed rail, equipment for the administration of oxygen, Hospital-type equipment for hemodialysis, kidney or renal dialysis (including training of a person to operate and maintain equipment), neuromuscular stimulators including TENS units and related supplies, and other durable medical or surgical equipment.

(o) Early intervention services

Early Intervention Services are covered for charges related to the treatment of conditions including, but not limited to, learning disabilities or developmental delays. Charges must be made for preventive and primary services for children. Covered Services include: Occupational therapy, speech therapy, physical therapy, nursing care, and psychological counseling.

(p) Family planning services including consultations and diagnostic tests

(q) Genetic counseling, testing and related services

See Preventive Care Services for BRCA testing

(r) Hearing aids (only for covered dependent children with a congenital abnormality)

(s) Home health care

Home Health Care Agency care in accordance with a home health care plan. Home health care means a visit by a member of a home health care team. Each such visit that lasts for a period of four (4) hours or less is treated as one (1) visit. Covered Services include:

(i) Part-time or intermittent nursing care rendered by a Registered Nurse (R.N.);

(ii) Services provided by a Licensed Practical Nurse (L.P.N.), a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse;

(iii) Services provided by home health aides;

(iv) Services of a medical social worker; and

(v) Medical supplies, drugs, and medications prescribed by a Physician and laboratory services by or on behalf of a Hospital to the extent such items would have been considered by this Plan had the Covered Person remained in the Hospital.

No benefits will be provided for services and supplies not included in the home health care plan, transportation services, Custodial Care and housekeeping, or for services of a person who ordinarily resides in the home of the Covered Person, or is a close relative of the Covered Person.

(t) Hospice care benefits are provided for Covered Persons with a life expectancy of less than six (6) months and a Hospice Plan of Care; respite services and bereavement counseling are available to members of his or her immediate family who are Covered Persons under this Plan. Benefits are limited to:

(i) Room and board for a confinement in a hospice;

(ii) Ancillary charges furnished by the hospice while the patient is confined therein, including rental of durable medical equipment which is used solely for treating an Injury or Illness;

(iii) Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;

(iv) Physician services and/or nursing care by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or a Licensed Vocational Nurse (L.V.N.);

(v) Home health aide service;

(vi) Home care charges for home care furnished by a Hospital or home health care agency, under the direction of a hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse, or a home health aide;

(vii) Medical social services by licensed or trained social workers, psychologists, or counselors;

(viii) Nutrition services provided by a licensed dietitian;

(ix) Respite care for Covered Persons who are members of the hospice patient's immediate family (for the purposes of hospice benefits, the term immediate family means – parents, Spouse and children); respite care coverage is provided only on an intermittent, non-routine and occasional basis and will not be covered for more than five (5) days at a time; and

(x) Bereavement counseling for Covered Persons who are members of the deceased's immediate family following the death of the terminally ill Covered Person. Benefits will be payable provided:

(a) On the date immediately before his or her death, the terminally ill person was a Covered Person under the Plan under a Hospice Plan of Care; and

(b) Charges for such services are incurred by the Covered Persons within six (6) months of the terminally ill Covered Person's death.

(u) Injectable medications which must be administered in the outpatient department of a Hospital or in a Physician's office

(v) Marital counseling when rendered by a licensed provider

(w) Medical and enteral formulas

Special medical and enteral formulas used in the treatment of, or in association with, a demonstrable disease, condition or disorder, or to treat malabsorption. (Regular grocery products that meet the nutritional needs of the patient are not covered; e.g. over-the-counter infant formulas such as Similac and Enfamil. Specialized formulas such as Nutramigen, Alimentum, or Neocate are covered.)

(x) Methadone maintenance and treatment

(y) Miscellaneous medical supplies (outpatient)

Expendable supplies that are used outside of a health care setting and are available only with a Physician's prescription. Covered medical supplies must be related to the use of medical equipment or devices, or are required as a result of medical or surgical treatment. Examples of covered medical supplies are colostomy bags, diabetic supplies, and supplies related to certain home care treatments.

(z) Modified low protein foods

Food products modified to be low protein to treat inherited diseases of amino acids and organic acids. The attending Physician must issue a written order stating that the food product is needed to sustain life, and is the least restrictive and most cost-effective means for meeting the Covered Person's medical needs

(aa) Occupational therapy

Treatment and services rendered by a licensed Occupational Therapist under the direct supervision of a Physician in a home setting or a facility whose primary purpose is to provide medical care for an Illness, Injury or developmental delays, or in a freestanding duly licensed outpatient therapy facility

(bb) Orthoptics

Treatment and services rendered by a certified orthoptist whose primary purpose is to diagnose and provide non-surgical management of certain eye movement disorders, such as strabismus, amblyopia, exotropia and/or esotropia in an outpatient setting, including a freestanding duly licensed outpatient therapy facility

(cc) Orthotics

For the purpose of treating an Illness or Injury, services and equipment such as orthopedic braces, including leg braces with attached shoes; arm, back and neck braces; surgical supports; head halters; and specially molded orthopedic shoes and/or orthotic inserts

(dd) Oxygen and other gasses and their administration

(ee) Physical therapy

Services rendered by a licensed Physical Therapist under direct supervision of a Physician in a home setting or facility whose primary purpose is to provide medical care for an Illness, Injury or developmental delays, or in a freestanding duly licensed outpatient therapy facility.

(ff) Podiatry care

Physician's services for symptomatic complaints related to the feet when corrected by a major surgical procedure or when the result of a serious medical condition, such as diabetes; routine services, including routine care for bunions, corns, calluses, toenails, flat feet, fallen arches, and chronic foot strain are excluded.

(gg) Private duty nursing

Services by a private duty nurse furnished by a Registered Nurse (R.N.), or Licensed Practical Nurse (L.P.N.), including charges billed by a Visiting Nurse Association, the need for which is substantiated by a written statement by the attending Physician.

Note: Services provided by an immediate member of the Employee's family or a nurse who resides in the Employee's home or provided on a twenty-four (24) hour basis are not Covered Services.

(hh) Prosthetics

Prosthetic appliances such as artificial arms and legs including accessories; larynx prosthesis; eye prosthesis; breast prosthesis (made necessary due to breast removal arising from Illness or Injury), and surgical brassieres when purchased following a mastectomy. Excludes replacement, repair or adjustment, unless the replacement, repair or adjustment is necessary because of physiological changes or the prosthesis that is being replaced is at least five (5) years old and no longer serviceable.

(ii) Rehabilitation Hospital

Inpatient confinement in a Skilled Nursing Facility and/or in a Rehabilitation Hospital if:

(i) Charges are incurred within fourteen (14) days following a Hospital confinement; and

(ii) The attending Physician certifies that twenty-four (24) hour nursing care is Medically Necessary for recuperation from the Illness or Injury which required the Hospital confinement.

(jj) Respiratory therapy

Inhalation therapy under the direct supervision of a Physician in a home setting or a facility whose primary purpose is to provide medical care for an Illness or Injury, or in a freestanding duly licensed outpatient therapy facility

(kk) Skilled Nursing Facility

Inpatient confinement in a Skilled Nursing Facility and/or in a Rehabilitation Hospital if:

(i) Charges are incurred within fourteen (14) days following a Hospital confinement, and

(ii) The attending Physician certifies that twenty-four (24) hour nursing care is Medically Necessary for recuperation from the Illness or Injury which required the Hospital confinement.

(ll) Sleep disorders

Sleep disorder testing, treatment, and related supplies, including diagnosis and treatment for Obstructive Sleep Apnea

(mm) Speech therapy

Services of a legally qualified Speech Therapist under the direct supervision of a Physician for restorative or rehabilitative speech therapy for speech loss or impairment, or due to surgery performed on account of an Illness, Injury or developmental delays. If speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy.

(nn) Telemedicine services

Medically Necessary telemedicine services for the purpose of diagnosis, consultation or treatment in the same manner as an in-person consultation between the Covered Person and the Provider. Telemedicine services are limited to the use of real-time interactive audio, video, or other electronic media telecommunications as a substitute for in-person consultation with Providers. Covered Services include:

(i) Telemedicine/telehealth visits

Interactive audio and video telecommunications system that permits real-time communication between a remote Provider and a Covered Person. Remote Providers who can furnish covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals

(ii) e-Visits/virtual visits

Non-face-to-face patient-initiated communications with a Covered Person's doctor(s) without going to the doctor's office by using

online patient portals. E-visits/virtual visits are covered when the Provider has an established relationship with the Covered Person

(oo) Temporomandibular joint disorders treatment, excluding devices or orthodontia

(pp) Voluntary sterilization

(qq) Voluntary termination of pregnancy

VI. MEDICAL LIMITATIONS AND EXCLUSIONS

The following are excluded from Covered Services and no benefits shall be paid for:

(1) Expenses incurred prior to the effective date of coverage under the Plan, or after coverage is terminated

(2) Claims submitted more than one (1) year after the Expense Incurred Date, unless the claim was delayed due to a Covered Person's legal incapacitation

(3) Physician travel or transportation expenses or broken appointments, except for benefits specifically stated as covered under the Plan

(4) Amounts in excess of the Contracted Rate for In-Network Providers or in excess of the Allowed Amount for Out-of-Network Providers

(5) Amounts in excess of the Usual and Reasonable Charge for outpatient dialysis services (see *Ususal and Reasonable Charge* under the Definitions section of this Plan, as well as *Dialysis/Hemodialysis-Outpatient* benefit in the Medical Benefits section)

(6) Services or supplies which are not considered Medically Necessary as defined in the Article titled "Definitions", whether or not prescribed and recommended by a Physician or covered provider, except for benefits specifically stated as covered under the Plan

(7) Experimental or Investigational drugs, devices, medical treatments or procedures as defined in the Article titled "Definitions"

(8) Services, supplies or treatment not recognized as generally accepted standards of medical practice for the diagnosis and/or treatment of an active Illness or Injury

(9) Treatment which is not the result of an Injury or Illness, except for benefits specifically stated as covered under the Plan

(10) Expenses incurred outside the United States if the Covered Person traveled to such location for the primary purpose of obtaining medical services, drugs or supplies

(11) Services, supplies and treatment which a Covered Person is entitled to receive without charge from any municipal, state or federal program. This exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare

(12) Expenses for which there is no legal obligation to pay, such as that portion of any charge which would not have been made if the patient did not have this coverage, or any charge for services or supplies which are normally furnished without charge

(13) Expenses incurred in connection with an Injury arising out of, or in the course of, any employment for wage or profit, or disease covered with respect to such employment, by any Worker's Compensation Law, Occupational Disease Law or similar legislation, with the exception of when a Covered Person is not covered by Worker's Compensation Law and lawfully chose not to be

(14) Expenses incurred in connection with an Injury arising out of, or in the course of, the commission of a crime by the Covered Person or while engaged in an illegal act, illegal occupation or felonious act, or aggravated assault for which the Covered Person is convicted of a felony charge. This exclusion does not apply to (a) Injuries sustained by a Covered Person who is a victim of domestic violence or (b) Injuries resulting from a medical condition (including both physical and mental health conditions)

(15) Medical expenses incurred on account of Injury or Illness resulting from war or any act of war, whether declared or undeclared, or expenses resulting from active duty in the Uniformed Services of any international armed conflict or conflict involving armed forces of any international authority

(16) Physician's fees for any treatment which is not rendered by or in the physical presence of a Physician except as specifically stated as covered under this Plan

(17) Communication, transportation, time spent traveling, or for expenses connected to traveling that may be incurred by a Physician, Covered Person, or covered provider, in the course of rendering services, except for benefits specifically stated as covered under the Plan

(18) Court-ordered treatment or any treatment not initiated by a Physician or covered provider of any kind

(19) Treatment, services or supplies provided by a member of the Covered Person's immediate family, any person who ordinarily resides with the Covered Person, or the Covered Person. The term immediate family includes, but is not limited to, the Covered Person's Spouse, child, brother, sister, or parent.

(20) Expenses incurred in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the Covered Person actually had such mandatory coverage. Any claims which arise in connection with an automobile accident for which the policy provides an option for medical coverage are excluded to the extent the Covered Person elects such optional medical coverage. This exclusion does not apply if the injured Covered Person is a passenger in a non-family owned vehicle or a pedestrian.

(21) Acupuncture therapy

(22) Biofeedback

(23) Chelation therapy

(24) Childbirth classes

(25) Cosmetic or reconstructive surgery, except for benefits specifically stated as covered under the Plan

(26) Custodial Care designed essentially to assist the Covered Person, whether disabled or not, in meeting the activities of daily living, including services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets and supervision over medication which can normally be self-administered. Such services and supplies are deemed to be Custodial Care whenever and wherever furnished, without respect to the practitioner or provider by whom or by which they are prescribed, recommended or performed, except for the Custodial Care described under benefits titled "Hospice Care."

(27) Dentures, dentistry, oral surgery, treatment of teeth and gum tissues or dental x-rays, except for benefits specifically stated as covered under the Plan

(28) Erectile dysfunction treatment, except medication covered under the Prescription Drug Benefit

(29) Eyewear, routine (including lenses, frames and contact lenses, and their fitting)

(30) Fluoride and fluoride varnish, for Covered Persons age 6 and older

(31) Food supplements, except for benefits specifically stated as covered

(32) Gender dysphoria treatment, including but not limited to, counseling, gender reassignment surgery or hormone therapy and related preoperative and postoperative procedures, which, as their objective, change the person's sex and any related complications

(33) Gene therapy

(34) Growth hormones

(35) Health/fitness club membership reimbursement, except as covered under Disease Management and Prevention Programs

(36) Hearing exam for routine care

(37) Home visits by visiting nurse after early maternity discharge

(38) Hypnosis, hypnotherapy, homeopathic treatment, Rolfing, Reiki, aromatherapy and alternative medicine, except for benefits specifically stated as covered under this Plan

(39) Infertility treatment including medicines and surgical procedures, except for services required to diagnose or treat underlying medical conditions

(40) Learning disabilities, behavioral problems, or developmental delay services or treatment, except for benefits specifically stated as covered

(41) Massage therapy

(42) Medical supplies that are incidental to the treatment received in a Physician or other provider's office or are provided as take-home supplies

(43) Naturopathic medicine

(44) "Over-the-counter" drugs or medical supplies which can be purchased without a prescription or when no Injury or Illness is involved, except for benefits specifically stated as covered under this Plan

(45) Pain clinic and pain management registration and program fees

(46) Pastoral counseling, music or art therapy (unless part of an inpatient program), assertiveness training, dream therapy, recreational therapy, stress management or other supportive therapies

(47) Personal comfort, hygiene or convenience items such as televisions, telephones, radios, air conditioners, humidifiers, dehumidifiers, physical fitness equipment, whirlpool baths, education, or educational aids or training whether or not recommended by a Physician

(48) Planned home births

(49) Podiatry services for routine care, including care for bunions, corns, calluses, toenails, flat feet, fallen arches and chronic foot strain

(50) Reverse sterilization

(51) Sex therapy

(52) Surrogate parenting, any expenses related to use of a gestational carrier

(53) Vision exams for routine care

(54) Visual refraction surgery, including radial keratotomy

(55) Vitamins, except for benefits specifically stated as covered under this Plan

(56) Weight loss programs, except as covered under Disease Management and Prevention Programs

(57) Wigs

VII. ELIGIBILITY, ENROLLMENT AND PARTICIPATION

Some of the terms used in this Article have special meanings under the Plan. These terms will always begin with capital letters. Please refer to Section D of this Article – Definitions for an explanation of these terms.

A. Eligibility

Employees and their Eligible Dependents are eligible to participate in the Plan as described below:

If the Employee is a(n):	**Then:**
New hire – ▪ Employee (reasonably expected to average 20 or more hours of service per week)	The Employee is eligible for coverage on the first day following the Waiting Period which is 31 days of continuous employment. Eligibility for coverage will continue at least until the first day of the first Standard Stability Period following completion of a Standard Measurement Period, provided the Employee remains employed.
New hire – ▪ Employee (reasonably expected to average fewer than 20 hours per week); ▪ Seasonal Employee (hired into position that typically lasts six months or less and begins/ends at generally same time each year)	The Employee's hours of service will be tracked over a 12-month Initial Measurement Period that begins on the first day of the month following date of hire to determine whether the Employee averages 20 or more hours of service per week. Employees who average 30 or more hours of service per week during the Initial Measurement Period will be eligible for coverage beginning on the first day of the month following completion of the Initial Measurement Period, which is also the first day of the Initial Stability Period. Eligibility for coverage will continue at least until the end of the Employee's Initial Stability Period, provided the Employee remains employed. Employees who average fewer than 20 hours of service per week during the Initial Measurement Period will not be offered coverage.
New hire – ▪ Change from reasonably expected to average fewer than 20 hours per week, Seasonal Employee to non-Seasonal position expected to average 20 or more hours per week during Initial Measurement Period	Coverage will be offered: ▪ On the later of the first day of the month following the change in employment status, or the date the Employee satisfies the Waiting Period, ▪ But in no event later than the first day of the 14th full calendar month of employment if hours of service during the Initial Measurement Period averaged 30 or more per week Eligibility for coverage will continue at least until the end of the Initial Stability Period, provided the Employee remains employed.
Ongoing Employee – • Employee who has been employed for a complete Standard Measurement Period	Hours will be tracked during each Standard Measurement Period: ▪ Employees who average 20 or more hours of service per week during the Standard Measurement Period will be eligible for coverage for as long as they remain employed during the following Standard Stability Period. ▪ Employees who average fewer than 20 hours of service per week will be ineligible for coverage for the following Standard Stability Period.

An Elected or Appointed Official is not subject to any minimum requirements for work hours per week.

Retirees (as defined under this Plan) and their Eligible Dependents are eligible to participate in this Plan, provided that the Retiree and his or her Eligible Dependents were participating in the Plan as of the date of retirement.

Hours of service include all hours for which an Employee is paid, including vacation and sick time or disability.

If an Employee is on an approved unpaid FMLA or military leave, or is on jury duty, then the weeks of unpaid time will not be included in the calculation of average hours of service for the purposes of determining eligibility for coverage for the following Stability Period. If the Employee is on any other type of unpaid leave, the weeks of unpaid time are included in the Measurement Period and credited with zero (0) hours of service for the purpose of determining eligibility for coverage for the following Stability Period.

B. Enrollment

To enroll in this Plan, an Employee or Retiree must elect coverage during an applicable enrollment period shown in the chart below. To make an election, all the required enrollment forms must be submitted to the Plan Administrator by the specified deadlines, unless due to administrative error.

In general, an Employee's or Retiree's election to enroll (or not enroll) for coverage under this Plan for the Employee, Retiree and/or Eligible Dependents is irrevocable for the duration of the Plan Year or Stability Period for which the election is made.

In certain limited circumstances, however, Employees may be eligible to change their elections to enroll for, cancel or change coverage for themselves and/or their Eligible Dependents during the Plan Year or Stability Period, provided that the required election/enrollment forms are submitted by the specified deadline.

The following chart summarizes the times when an Employee or Retiree may enroll or change a current election under this Plan and, the applicable enrollment/election deadlines. The requirements for making elections during each period are detailed in the chart below.

Enrollment/Election Periods

Enrollment/Election Due To:	**Enrollment/Election Deadline:**
1. Initial Eligibility Period	Within thirty-one (31) days from completion of the Waiting Period
2. Open Enrollment Period	The last day of the annual enrollment period specified by the Plan Administrator
3. Qualified Change in Status	Thirty-one (31) days after the date of the Qualifying Change in Status*
4. Special Enrollment Period following a gain or loss of eligibility for Medicaid or CHIP	Sixty (60) days after the date of the loss or gain of eligibility for Medicaid or CHIP
5. HIPAA Special Enrollment Period ***a. Following loss of other coverage or*** ***b. Acquisition of Eligible Dependent***	Thirty-one (31) days after the date of the loss of other coverage or acquisition of Eligible Dependent*

6.Retirement	Thirty-one (31) days from the date of retirement

*In the case of an adopted child, this means the date the child is placed with the Employee for adoption

Enrollment Requirements for Newborn Children.
A newborn child of a Covered Employee who has family coverage is **not automatically** enrolled in this Plan. For coverage to be retroactive to the date of birth, enrollment must be made within thirty-one (31) days of the birth. If the child is not enrolled within thirty-one (31) days of birth, the enrollment will be considered a Late Enrollment, subject to "Open Enrollment" rules.

(1) Initial Eligibility Period

An Employee may elect to enroll in this Plan no later than 31 days following completion of the Employee's Waiting Period by submitting all required forms to the Plan Administrator. Any election made to enroll or not to enroll during the initial eligibility period will be irrevocable for the duration of the Stability Period, unless the Employee becomes eligible to change an election during an enrollment period described below. For subsequent Stability Periods, an Employee may change his or her election during the open enrollment period.

(2) Open Enrollment Period

During open enrollment periods held on dates determined by the Plan Administrator, an Employee may change elections with respect to enrollment in this Plan for the Employee, and/or Eligible Dependents. In the absence of an affirmative election during an open enrollment period, an eligible Employee's election with respect to participation in this Plan which is in effect as of the last day of the Stability Period will automatically carry over for the following Stability Period.

Note: This provision does not apply to Retirees.

(3) Qualified Change in Status

An Employee or Retiree may change an election with regard to coverage under this Plan after the initial eligibility period and outside an open enrollment period or retirement election period following a Qualified Change of Status as permitted under the Internal Revenue Code of 1986, as amended. The Qualified Changes of Status that are applicable under this Plan include:

- Marriage, legal separation, annulment, establishment or dissolution of domestic partnership, or divorce of the Employee or Retiree;
- Birth, adoption or placement for adoption, or change in custody of the Employee's child;
- Death of the Employee's or Retiree's Spouse, domestic partner, or other Eligible Dependent;

- A child's loss or gain of Eligible Dependent status;
- An Employee's, domestic partner's, or Spouse's commencement of or return from an unpaid leave of absence;
- A significant change in the cost or coverage of the Employee's, Retiree's, domestic partner's, or Spouse's employer-provided health care coverage;
- A Spouse's or domestic partner's employer's open enrollment period during which the Spouse or domestic partner changes his or her election regarding health care coverage;
- A change in employment status for the Employee, domestic partner, or Spouse, with corresponding changes in eligibility for coverage under either employer's plan;
- A reduction in an Employee's hours to fewer than 30 per week without regard to whether the change causes a loss of eligibility under this Plan if the Employee intends to enroll in another plan that provides Minimum Essential Coverage (MEC) as defined under the Affordable Care Act;
- An Employee's or Retiree's intention to enroll in a Qualified Health Plan through a Health Insurance Marketplace ("Marketplace") due to eligibility for a Special Enrollment Period (e.g., marriage, birth of child), where the Employee revokes coverage under this Plan, provided coverage under the Qualified Health Plan begins on the day immediately following the loss of coverage under this Plan;
- A Spouse, domestic partner, or other Eligible Dependent becomes employed or unemployed; and
- Other Qualified Changes in Status as may be permitted under the Internal Revenue Code of 1986, as amended.

A change to an election under this section may be to enroll for coverage, terminate coverage or change coverage level under this Plan, provided the election change is consistent with the qualifying change in family or employment status. For example, an Employee who gets married may elect to drop coverage under this Plan to enroll in his or her new Spouse's plan or may elect to add the new Spouse and/or stepchildren to this Plan.

To make an election change under this section, the Employee or Retiree must submit a completed enrollment form to the Plan Administrator, with documentation of the qualifying change in family or employment status, within thirty-one (31) days of the applicable change.

Note: Retirees may also make a change to their election based on the applicable guidelines above.

(4) Special Medicaid/CHIP Enrollment Period

If an Employee is not covered under this Plan, or is covered but has not enrolled any Eligible Dependents, the Employee may elect to enroll and may elect to enroll any Eligible Dependents if:

(a) The Employee's or an Eligible Dependent's coverage under Medicaid or CHIP is terminated as a result of loss of eligibility under such programs, or the Employee or Eligible Dependent becomes newly eligible for premium subsidy through Medicaid or CHIP to help pay the cost of coverage under this Plan; and

(b) The Employee submits a completed enrollment form to the Plan Administrator, with documentation of the loss of Medicaid or CHIP coverage, or of new eligibility for Medicaid or CHIP premium subsidy, within sixty (60) days of the date of the applicable loss of coverage or new eligibility for the premium subsidy.

Note: This provision does not apply to Retirees.

(5) HIPAA Special Enrollment Period Following Involuntary Loss of Other Coverage or Acquisition of Eligible Dependent

(a) Enrollment following involuntary loss of other coverage

An Employee who is not participating in the Plan, but meets the eligibility requirements, may elect to enroll himself or herself and any of his or her Eligible Dependents if all the conditions below are met:

(i) The Employee declined coverage under the Plan for the Employee and any Eligible Dependents when it was offered previously;

(ii) The Employee signed a written waiver of coverage under this Plan whenever such coverage was offered, giving the existence of alternative health coverage as the reason for waiving the coverage, on forms furnished by and delivered to the Plan Administrator within the specified enrollment period each time such coverage was offered;

(iii) The alternative health coverage was involuntarily lost because:

- It was COBRA continuation coverage that has been exhausted;
- Eligibility for the alternative coverage was lost (for reasons other than the Employee's voluntary cancellation of the coverage, failure to pay premiums or for cause);
- All benefits under the alternative coverage have been exhausted under its lifetime benefit limits; or

- Employer contributions toward the cost of the alternative coverage terminated.

(iv) The Employee submits a completed enrollment form to the Plan Administrator, with written documentation that confirms the involuntary loss of alternative coverage, within thirty-one (31) days after the date on which the alternative coverage was involuntarily lost.

(b) Enrollment following acquisition of Eligible Dependents

If an Employee is not covered under this Plan, but meets the eligibility requirements, the Employee may be eligible to enroll and may be eligible to enroll any Eligible Dependents if all the conditions below are met:

(i) Another individual (a Spouse or child) has become an Eligible Dependent of the Employee through marriage or domestic partnership, birth, adoption, or placement for adoption; and

(ii) The Employee submits a completed enrollment form to the Plan Administrator, with written documentation of the acquisition of the new dependent, within thirty-one (31) days of the marriage or domestic partnership, birth, adoption, or placement for adoption.

Note: This provision does not apply to Retirees.

(6) Enrollment due to Retirement

An Employee who terminates employment and is a Retiree as defined under this Plan may elect to enroll for retirement coverage for himself or herself and any Eligible Dependents within thirty-one (31) days of retirement.

C. Participation

The chart below provides an overview of when participation begins or ends based on a permitted election, provided all enrollment materials are submitted by the deadlines shown under Section B, *Enrollment*. Coverage and participation under this Plan begin and end on the same date.

When Participation Begins/Ends

Election during	Participation for Employee	Participation for Eligible Dependents enrolled by Employee
1. Initial Eligibility Period	Begins on: ▪ The date shown for new hires reasonably expected to average 20 or more hours of service per week under Section A above	Begins on the later of: ▪ The date the Employee's or Retiree's coverage begins, if Eligible Dependents were enrolled on or before that date, or ▪ The date of enrollment
2. Open Enrollment Period	Begins or ends, as applicable, on the first day of the Stability Period following the end of the Open Enrollment Period	
3. Enrollment Period following Qualified Change in Status	Begins or ends on the date of the Qualified Change of Status* except as follows: ▪ Coverage revoked due to a reduction in hours ends on the date specified by the Employee, but no earlier than the date the revocation is received by the Plan Administrator, and no later than the last day of the month following the month the coverage was revoked	
4. Special Enrollment Period: Gain or loss of eligibility for Medicaid or CHIP	Begins or ends, as applicable, on the date of the loss or gain of eligibility for Medicaid or CHIP	
5a. HIPAA Special Enrollment Period: Loss of other coverage	Begins on date of loss of coverage	
5b. Special Enrollment Period: Acquisition of Eligible Dependent	Begins or ends, as applicable, on date of acquisition of Eligible Dependent*	

*In the case of adoption, this means the date the child is placed for adoption.

(1) Participation during Periods of Leave of Absence or Disability

In all cases where an Employee is eligible and elects to continue coverage during periods of absence from work as described below, the Employer's obligation to provide ongoing coverage under this Plan ceases if the Employee is more than thirty (30) days late in making the required contributions.

Note: Eligibility to remain in the plan will continue beyond the leave provisions stated below if application of the Measurement and Stability Period provisions set forth in the Eligibility section result in a longer period of time.

(a) Leave of Absence under FMLA

A covered Employee who is entitled to and takes a family or medical leave under the terms of the FMLA (Family and Medical Leave Act of 1993, as amended), and any covered dependents, may continue to participate in this Plan until the earliest of:

(i) The expiration of the leave, or

(ii) The date the Employee gives notice to the Employer that the Employee does not intend to return to work at the end of the FMLA Leave.

(b) Leave of Absence for Military Service

A covered Employee who is absent from work due to military service and any covered dependents may continue to participate in this Plan for up to 24 months provided the Employee continues to make any required contributions.

(c) Leave of Absence under State-Mandated Family or Medical Leave

A covered Employee who is absent from work due to an approved state-mandated family or medical leave, may continue to participate in this Plan for a period up to the maximum permissible timeframe under the applicable state-mandated family or medical leave, subject to payment of the necessary contributions. If the Employee does not return to an Actively at Work status after the expiration of the leave or does not continue the necessary contributions, coverage under the Plan will be terminated and continuation of coverage under COBRA will be offered.

(d) Other Approved Leave of Absence (other than FMLA Leave, Military Service Leave or State-Mandated Family or Medical Leave)

A covered Employee who is absent from work on a full-time basis due to an approved leave of absence and who is not engaged in any other occupation for compensation, profit or gain, may continue to participate in this Plan for a period of up to twelve (12) consecutive months beginning from the date last worked provided the Employee continues the necessary contributions. If the Employee does not return to an Actively at Work status upon expiration of the leave, or does not continue the necessary contributions, coverage under the Plan will be terminated and continuation of coverage under COBRA will be offered.

(e) Disability (other than under FMLA Leave or State-Mandated Family or Medical Leave)

A covered Employee who is absent from work and who is Totally Disabled as defined under this Plan (other than under FMLA Leave or state-mandated family or medical leave), may continue to participate in this Plan for a period of up to twelve (12) consecutive months, subject to payment of the necessary contributions. If the Employee does not return to an Actively at Work status after twelve (12) consecutive months or does not continue the necessary contributions, coverage under the Plan will be terminated and continuation of coverage under COBRA will be offered.

The above noted leave(s), with the exception of a Leave of Absence not meeting the definition of an FMLA Leave, run concurrently with FMLA, USERRA or any state-mandated family or medical leave, and/or any other applicable leaves of absence.

(2) Participation for Employees under Compensation Maintenance Agreements, Retirement Agreements, and/or Severance Agreements

Employees who enter into special written agreements with the Employer are eligible to continue participation in the Plan following termination of employment as specified under the terms of each individual's agreement. In each such case, coverage following termination of employment continues for the period specified under the terms of each individual's agreement, and then continuation of coverage under COBRA will be offered.

(3) Participation in Cases of Return to Work or Reemployment

(a) Return from FMLA Leave

Participation in the Plan will begin immediately for, any Covered Person who discontinued coverage during a leave of absence taken under the FMLA by the Employee, provided the Employee returns to Actively at Work status before or immediately following the expiration of the FMLA Leave, and provided that the Employee is eligible for coverage upon return in accordance with the provisions of Section A of this Article, Eligibility.

(b) Return from Military Service Leave

Participation in the Plan will begin immediately for an Employee absent from work due to military service, and for dependents covered under the Plan when the military service began, on the first day the Employee returns to Actively at Work status, whether or not an Employee elects COBRA continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), provided that the Employee is eligible for coverage upon return in accordance with the provisions of Section A of this Article, Eligibility, and the Employee returns to Actively at Work status:

(i) On the first full business day following completion of the military service for a leave of thirty (30) days or less; or

(ii) Within fourteen (14) days of completing military service for a leave of thirty-one (31) to one hundred eighty (180) days; or

(iii) Within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days.

In each case, a reasonable amount of travel time or recovery time for an Illness or Injury determined by the Veterans' Administration to be service connected will be allowed.

(c) Return from State-Mandated Family or Medical Leave

Participation in the Plan will begin immediately for any Covered Person who discontinued coverage during a leave of absence taken under a state-mandated family or medical leave by the Employee, provided the Employee returns to Actively at Work status before or immediately following the expiration of the state-mandated family or medical leave, and provided that the Employee is eligible for coverage upon return in accordance with the provisions of Section A of this Article, Eligibility.

(d) Return from Disability or other Approved Leave of Absence (other than FMLA Leave, Military Service Leave or State-Mandated Family or Medical Leave)

Participation in the Plan will begin immediately for an Employee and any dependents whose coverage was discontinued during a period of disability or other approved leave of absence, provided the Employee returns to Actively at Work status immediately upon the expiration of the approved leave, or upon no longer being Totally Disabled (if earlier), and provided the Employee is eligible for coverage in accordance with the provisions of Section A of this Article, Eligibility.

(e) Reemployment While Covered under COBRA

Participation in the Plan will begin immediately for any former enrolled Employee and any Eligible Dependents who have continuously been covered under this Plan through COBRA continuation coverage provided the Employee is eligible for coverage in accordance with the provisions of Section A of this Article, Eligibility.

(f) Reemployment in General

The provisions below apply to former Employees and their dependents who were covered under the Plan on the date the Employee terminated employment and who do not fall into the categories described in (a) through (d) above.

(i) A rehired Employee who was a participant in the Plan on the date of employment termination may resume participation in the Plan on the date of rehire if the Employee is reemployed fewer than 4 weeks following termination of employment, or if the Employee has not had a Break-in-Service, provided that either:

a. The Stability Period on the date of reemployment is the same as the Stability Period in effect on the date of employment termination, or,

b. If reemployment begins during a new Stability Period, the Employee is eligible for coverage in accordance with the provisions of Section A of this Article, Eligibility.

(ii) In the case of a reemployed Employee eligible to participate under the conditions stated in (i) above, but who had not satisfied the Waiting Period as of the termination date, the Waiting Period will be reduced by the period of prior employment and the period between the date of termination and date of rehire.

(iii) In cases of reemployment following a Break-in-Service, eligibility to participate will be determined in accordance with the provisions of Section A of this Article, Eligibility, as they relate to new hires.

D. Definitions

For purposes of this Article, the following words and phrases will have the following meanings when used in the Plan, unless a different meaning is plainly required by the context:

Break-in-Service – following an Employee's termination of employment: a) a period of 13 or more consecutive weeks during which an Employee has not had an hour of service or b) a period of 4 or more, but fewer than 13 consecutive weeks during which an Employee has not had an hour of service, where such period exceeds the Employee's period of prior employment.

Health Insurance Marketplace or Exchange – a resource available in each state that helps individuals learn about health coverage, and about paying for health coverage and available subsidies, and offers individuals and families the opportunity to enroll in Qualified Health Plans.

Initial Measurement Period – a 12-month period that begins on the first day of the month following date of hire during which the hours of service for Seasonal Employees and Employees reasonably expected to average fewer than 20 hours per week are tracked to determine eligibility for coverage during the Initial Stability Period.

Initial Stability Period – a 12-month period that begins on the first day of the month after completing Initial Measurement Period during which an Employee's status as eligible or ineligible for coverage is locked in based on average hours of service during the Initial Measurement Period.

New Employee – an Employee who has not been employed for an entire Standard Measurement Period or a returning Employee who has had a Break-in-Service.

Ongoing Employee – an Employee who has been employed for a complete Standard Measurement Period.

Qualified Health Plan – a health plan offered through and certified by a Health Insurance Marketplace or Exchange.

Seasonal Employee – a New Employee hired into a position which customarily lasts six months or less and which begins and ends at approximately the same time each Calendar Year.

Standard Measurement Period – the 12-month period during which all Employees' hours of service are tracked to determine eligibility or ineligibility for coverage for the following Standard Stability Period. The dates for the Standard Measurement Period are determined by the Employer each year.

Standard Stability Period – the 12-month period that begins on the first day of each Plan Year, during which every Ongoing Employee's status as eligible or ineligible for coverage is locked in based on average hours of service during the Standard Measurement Period.

Waiting Period - the period of time, if any, an eligible Employee must be employed by the Employer before coverage begins under this Plan.

VIII. COORDINATION OF BENEFITS

A. Maximum Benefits Under All Plans

If any Covered Person under this Plan also is covered under one or more Other Plans and the sum of the benefits payable under all the Plans exceeds the Covered Person's Eligible Charges during any Claim Determination Period, then the benefits payable under all the Plans involved will not exceed the Eligible Charges for such period as determined under this Plan. Benefits payable under any Other Plan are included, whether or not a claim has been made. For these purposes:

(1) "Claim Determination Period" means a Calendar Year, and

(2) "Eligible Charge" means any necessary, reasonable, and customary item of which at least a portion is covered under this Plan, but does not include:

(a) Charges specifically excluded from benefits under this Plan that also may be eligible under any Other Plans covering the Covered Person for whom the claim is made

(b) Charges related to retail or mail-order (if applicable) prescription drug claims which are administered by the Prescription Drug Manager for this Plan

B. Other Plan

"Other Plan" shall include, but is not limited to::

(1) Any primary payer besides this Plan;

(2) Any other group health plan;

(3) Any other coverage or policy covering the Covered Person;

(4) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state;

(5) Any policy of insurance from any insurance company or guarantor of a responsible party;

(6) Any policy of insurance from any insurance company or guarantor of a third party;

(7) Workers' compensation or other liability insurance company; and

(8) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

C. Excess Insurance

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

The Plan's benefits will be excess to, whenever possible, any of the following:

(1) Any primary payer besides this Plan;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state;

(3) Any policy of insurance from any insurance company or guarantor of a third party;

(4) Workers' compensation or other liability insurance company; and

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

D. Vehicle Limitation

When medical payments are available under any vehicle insurance, this Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the Medical Limitations and Exclusions provisions set forth in this Plan. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles or classifications.

E. Determining Order of Payment

If a Covered Person is covered under two or more health plans, the order in which benefits are paid will be determined as follows:

(1) The plan covering the Covered Person other than as an Eligible Dependent, for example as an Employee, member, subscriber, policyholder or retiree, pays benefits first. The plan covering the Covered Person as an Eligible Dependent pays benefits second.

(2) If no plan is determined to have primary benefit payment responsibility under (1), then the plan that has covered the Covered Person for the longest period has the primary responsibility.

(3) A plan that has no coordination of benefits provision will be deemed to have primary benefit payment responsibility.

(4) The plan covering the parent of the Eligible Dependent child pays first if the parent's birthday (month and day of birth, not year) falls earlier in the year. The plan covering the parent of an Eligible Dependent child pays second if the parent's birthday falls later in the year.

(5) In the event that the parents of the Eligible Dependent child are divorced or separated, the following order of benefit determination applies:

(a) The plan covering the parent with custody pays benefits first;

(b) If the parent with custody has not remarried, then the plan covering the parent without custody pays benefits second;

(c) If the parent with custody has remarried, then the plan covering the step-parent pays benefits second and the plan covering the parent without custody pays benefits third; and

(d) If a divorce decree or other order of a court of competent jurisdiction places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent pays benefits first.

(6) The plan covering the Covered Person as an Employee (or as that Employee's Eligible Dependent) pays benefits first unless the Employee is laid-off or retired. The plan covering the Covered Person as a laid-off or retired Employee (or as a laid-off or retired Employee's Eligible Dependent) pays benefits second.

(7) The plan covering a Covered Person as an Employee (or as an Eligible Dependent of the Employee) pays benefits first if such an individual is also being provided COBRA continuation coverage under any Other Plan, and such Other Plan pays benefits second for such an individual. Conversely, this Plan pays secondary benefits for any Employee who is provided COBRA continuation under this Plan and who also is covered simultaneously under the Other Plan as an Employee (or as an Eligible Dependent of an Employee). In the event of conflicting coordination provisions between this Plan and any Other Plan, this Plan will pay primary benefits for an individual only if this Plan has provided coverage for a longer period of time.

F. Facilitation of Coordination

For the purpose of Coordination of Benefits, the Claim Administrator:

(1) May release to, or obtain from, any other insurance company or other organization or individual any claim information and any individual claiming benefits under this Plan must furnish any information that the Plan sponsor may require

(2) May recover on behalf of this Plan any benefit overpayment from any other individual, insurance company, or organization

(3) Has the right to pay to any other organization an amount it will determine to be warranted, if payments that should have been made by this Plan have been made by such organization

G. Persons Covered by Medicare

A Covered Person who becomes entitled to medical benefit coverage under Medicare shall remain eligible for benefits under this Plan on the same terms and conditions as any other Covered Person. This Plan will coordinate benefits with Medicare in accordance with the rules of the Medicare Secondary Payor (MSP) Program as promulgated by the Centers for Medicare & Medicaid Services (CMS) as may be amended from time to time. The Medicare Secondary Payor rules under Social Security Act §1862(b) (42 U.S.C. §1395y(b)(5)), as may be amended from time to time, and applicable Federal regulations are hereby incorporated by reference and shall supersede any inconsistent provision(s) of this Plan. These rules will determine when this Plan will be the primary payer of Covered Services and when Medicare will be the primary payer.

In the event that this Plan would otherwise be allowed (as in accordance with the Medicare Secondary Payor rules) to be a secondary payor of Covered Services for Covered Persons who are eligible for Medicare, benefits for Covered Services incurred for Covered Persons eligible for Medicare but who have not applied for entitlement to Medicare Part A or Part B or who have applied for entitlement to Part A and/or Part B, but have chosen not to elect Part B, will not be offset by amounts that would be payable under Medicare Parts A and B if the Covered Person did not apply for entitlement to Medicare Part A and B.

H. Discrimination Against Older Participants Prohibited

This Plan will provide benefits for any Covered Person age 65 or older under the same terms and conditions that apply to a Covered Person who is under age 65.

I. Enrollment and Provision of Benefits without Regard to Medicaid Eligibility

In enrolling an Employee as a Covered Person or in determining or making any payments for benefits of an Employee as a Covered Person, the fact that the Employee is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

J. Plan Charges Covered by Medicaid or CHIP (Children's Health Insurance Plan)

This Plan will not reduce or deny benefits for any Covered Person to reflect the fact that such a Covered Person is eligible to receive medical assistance through Medicaid or CHIP.

K. Medicare and Medicaid Reimbursements

The Plan will reimburse the Centers for Medicare and Medicaid Services or any successor government agency for the cost of any items and services provided by Medicare for any

Covered Person that should have been borne by this Plan. Similarly, this Plan will reimburse any state Medicaid program for the cost of items and services provided under the state plan that should have been paid for by this Plan.

L. Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this Section or any provision of similar purpose of any Other Plan, a Covered Person may be required to provide confirmation regarding any other health coverage the Covered Person may have and must furnish information regarding such coverage as may be necessary to implement this provision. Until confirmation regarding any other coverage is provided, payment of the Covered Person's claims under this Plan may be delayed and claims may be denied if confirmation is not received. In addition, the Employer, through its authorized administrator, may, without the consent of or notice to any person to the extent permitted by law, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which is deemed to be necessary for such purposes.

M. Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision, have been made under any Other Plans, the Employer will have the sole right and discretion to pay over to any organizations making such other payments any amounts it will determine to be warranted in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan.

N. Right of Recovery

Whenever payments have been made by the Employer with respect to Covered Services in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Employer will have the right to recover such payments to the extent of such excess from any persons to or for or with respect to whom such payments were made and any other insurance companies and any other organizations.

IX. PLAN ADMINISTRATION

A. Plan Administrator

The Plan Administrator will be appointed by the Employer.

B. Allocation of Authority

Except as to those functions reserved by the Plan to the Employer or the Board of Directors of the Employer or the PAE, the Plan Administrator will control and manage the operation and administration of the Plan. The Plan Administrator shall (except as to matters reserved to the Board of Directors or the PAE by the Plan or that the Board may reserve to itself) have the sole and exclusive right and discretion:

(1) To interpret the Plan, the Summary Plan Description, and any other writings affecting the establishment or operation of the Plan, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits, and to decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions. Notwithstanding the foregoing; the Plan Administrator has delegated to the PAE discretion, control and exclusive duty and authority to determine what constitutes a covered benefit under the Plan for claims payment or denials pertaining to second level appeal determination for post-service claims as in accordance with the terms and provisions set forth under Article VI of this Plan entitled "Claims and Appeals Procedures and Statement of ERISA Rights."

(2) To make factual findings and decide conclusively all questions regarding any claim for benefits under the Plan, or to delegate such responsibility to the PAE in accordance with section B(1) above.

All determinations of the Plan Administrator or the Board of Directors or the PAE, as applicable, with respect to any matter relating to the administration of the Plan will be conclusive and binding on all persons.

C. Powers and Duties of Plan Administrator

The Plan Administrator will have the following powers and duties:

(1) To require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the Plan as a condition to receiving any benefits under the Plan

(2) To make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator will deem necessary for the efficient administration of the Plan

(3) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan, in accordance with the provisions of the Plan

(4) To determine the payment of benefits for claims in accordance with the provisions of the Plan, or to delegate such responsibility to the PAE in accordance with section B(1) above; to inform the Employer, as appropriate, of the amount of such Benefits; and to provide a full and fair review to any Covered Person whose claim for benefits has been denied in whole or in part

(5) To designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility of the Plan Administrator under the terms of the Plan; and to retain such actuaries, accountants (including Employees who are actuaries or accountants), consultants, third-party administration service providers, legal counsel, or other specialists, as the Plan Administrator may deem appropriate and necessary for the Plan's effective administration

D. Delegation by the Plan Administrator

The Plan Administrator may employ the services of such persons (including an insurance company or third party administrator) as it may deem necessary or desirable in connection with the administration of claims or other operations of the Plan. The Plan Administrator may also appoint a benefit committee consisting of not less than three (3) persons to assist the Plan Administrator either generally or specifically in reviewing claims for benefits, subject to the right of the Board of Directors to replace any or all of the members of the committee, or to eliminate the committee entirely.

The Plan Administrator also will have the power and duty to retain the services of one or more health care professionals, for the purpose of reviewing benefit claims that are under appeal for reasons based on medical judgment, such as medical necessity or experimental treatments.

The Plan Administrator, the Employer (and any person to whom any duty or power in connection with the operation of the Plan is delegated), may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly appointed actuary, accountant (including Employees who are actuaries or accountants), consultant, third-party administration service provider, legal counsel, or other specialist, and the Plan Administrator, Employer, or such delegate will be fully protected in respect to any action taken or permitted in good faith in reliance on such table, valuations, certificates, etc.

When the Plan Administrator assigns the PAE the task of making a determination regarding first and second level appeals for claims, the PAE shall possess the rights and exercise the duties otherwise ascribed to the Plan Administrator only insofar as it relates to said appeals for claims.

E. Fiduciary Liability

The Plan Administrator is the named fiduciary under the Plan except as to the functional fiduciary duties extended to the PAE.

The PAE is a functional fiduciary for the appeals it performs but only to the extent that the PAE has final discretionary authority to determine what benefits are paid as set forth under the terms of the Plan. The PAE is not a fiduciary for any other activity, function or purpose. The PAE shall not have fiduciary duties in all other matters, including, but not limited to, matters the Plan Administrator is prohibited from referring to the PAE in accordance with applicable law and/or pre-existing contract.

The PAE shall at all times strictly abide by, and make determination(s) in accordance with, the terms of the Plan and applicable law.

F. Indemnification and Exculpation

The Plan Administrator and the members of any committee appointed by the Plan Administrator to assist in administering the Plan, its agents, and officers, directors, and Employees of the Employer will be indemnified and held harmless by the Employer against and from any and all loss, cost, liability, or expense that may be imposed upon or reasonably incurred by them in connection with or resulting from any claim, action, suit, or proceeding to which they may be a party or in which they may be involved by reason of any action taken or failure to act under this Plan and against and from any and all amounts paid by them in settlement (with the Employer's written approval) or paid by them in satisfaction of a judgment in any such action, suit, or proceeding. Indemnification under this Section will not be applicable to any person if the loss, cost, liability, or expense is due to the person's failure to act in good faith or misconduct.

G. Compensation of Plan Administrator

Unless otherwise agreed to by the Board of Directors, the Plan Administrator will serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of the Plan Administrator's duties will be paid by the Employer.

H. Bonding

Unless required by federal or state law, neither the Plan Administrator nor any of the Plan Administrator's delegates will be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

I. Payment of Administrative Expenses

All reasonable expenses incurred in administering the Plan, including but not limited to administrative fees and expenses owing to any third-party administrative service provider, actuary, consultant, accountant, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, will be paid by the Employer unless the Employer directs the Plan to pay such expenses and such payment by the Plan is permitted by law.

X. TERMINATION AND CONTINUATION OF COVERAGE

A. Termination of Coverage

(1) Termination Events

Participation in and coverage under this Plan for any Employee and Eligible Dependents terminates on the earliest of:

(a) The day the Employee terminates employment

(b) The day the Employee ceases to be in a class of eligible Employees as described in the *Eligibility, Enrollment and Participation* section in this document

(c) The day the Employee fails to return to Actively at Work status following expiration of an approved leave of absence

(d) The day the Employer terminates the Employee's coverage

(e) The day this Plan terminates

(f) The day the Employee dies

(g) The day the Employee enters service in the Uniformed Services on an active duty basis

(h) The first day of the period for which the Employee fails to make any required contributions

Participation in and coverage under this Plan for any Retiree and his or her Eligible Dependents terminates on the earliest of:

(a) The first day of the month the Retiree becomes eligible for Medicare, unless Medicare eligibility is due to End Stage Renal Disease (ESRD)

(b) The day this Plan terminates

(c) The first day of the period for which the Retiree fails to make any required contributions

(d) The day the Retiree dies; however, the surviving Spouse and dependent children may continue Plan coverage if the required contribution is paid, until they no longer satisfies the definition of an Eligible Dependent as defined in the *Definitions* section of this document

Note: Once coverage is terminated, Retirees are not eligible to re-enroll at any later date.

(2) Earlier Termination of Eligible Dependent Coverage

Participation in and coverage under this Plan of any Employee's Eligible Dependent who loses eligibility prior to the Employee's termination from the Plan will terminate on the earliest of:

(a) The last day of the month in which an Eligible Dependent child turns age 26; or

(b) The date that the dependent no longer satisfies the definition of an Eligible Dependent as defined in the *Definitions* section of this document; or

(c) The first day of the period in which the Employee fails to make any required contribution for Eligible Dependent coverage.

Participation in and coverage under this Plan for any Retiree's Eligible Dependent who loses eligibility prior to the Retiree's termination from the Plan will terminate on the earliest of:

(a) The day the Eligible Dependent ceases to be in a class of Eligible Dependents as defined in the *Definitions* section of this document.

(b) The day the Eligible Dependent becomes eligible for Medicare, unless Medicare eligibility is due to End Stage Renal Disease (ESRD).

(c) The first day of the period in which the Retiree fails to make any required contribution for Eligible Dependent coverage.

(3) Rescissions

In general, coverage may not be retroactively terminated under this Plan, except in cases of: a) fraud or intentional misrepresentation of material fact related to an Employee's or dependents' coverage under the Plan, b) failure to notify the Plan about a dependent's loss of eligibility for coverage under the Plan in a timely manner, or c) failure to pay required premiums or contributions in a timely manner. If coverage is retroactively terminated for any of these reasons, an Employee may be responsible for any benefit payments made during the relevant period. For any rescission (retroactive termination of coverage that is related to fraud or intentional misrepresentation), the Plan Administrator will provide thirty (30) days advance written notice and an Employee will have the right to appeal the Plan's termination of coverage.

B. COBRA (Consolidated Omnibus Budget Reconciliation Act, as amended)

During any Plan Year during which the Employer has more than 20 Employees (as defined under COBRA for this purpose), each person who is a Qualified Beneficiary, as defined below, has the right to elect to continue coverage under this Plan upon the occurrence of a Qualifying Event, as defined below, that would otherwise result in a loss

of coverage under the Plan. Extended coverage under the Plan is known as "COBRA continuation coverage" or "COBRA coverage."

COBRA coverage is group health insurance coverage that an employer must offer to certain Plan participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of certain events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage will be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage will be identical to the coverage provided to similarly situated active Employees or Retirees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

When a covered Employee and the Employee's covered dependents become eligible for COBRA, they may also become eligible for other coverage options that may cost less than COBRA continuation coverage. For example, a covered Employee and the Employee's covered dependents may be eligible to enroll through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." By enrolling in these other coverage options, an Employee may qualify for lower costs on monthly premiums and/or lower out-of-pocket costs.

Additional information about many of these options can be found at www.healthcare.gov.

(1) Qualified Beneficiaries

In general, a Qualified Beneficiary* is:

(a) Any Employee who, on the day before a Qualifying Event, is covered under the Plan. If, however, an Employee is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the Employee will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that Employee experiences a Qualifying Event.

(b) The Spouse or Eligible Dependent child of a covered Employee or Retiree who, on the day before a Qualifying Event, is covered under the Plan.

(c) Any child who is born to or placed for adoption with a covered Employee or Retiree during a period of COBRA continuation coverage.

(d) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Eligible Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event,

the Spouse, surviving Spouse or Eligible Dependent child was a beneficiary under the Plan.

*A Qualified Beneficiary will also include any Eligible Dependent as defined in the General Definitions section under this Plan who is a domestic partner or child of a domestic partner.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any Employee who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed Employees, independent contractor, or corporate director).

An Employee is not a Qualified Beneficiary if the Employee's status as a covered Employee is attributable to a period in which the Employee was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. Nor are such Employee's Spouse or Eligible Dependent children considered Qualified Beneficiaries.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee or Retiree during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

(2) Qualifying Events

A Qualifying Event is any of the following if the Plan provides that the Qualified Beneficiary would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(a) The death of a covered Employee or Retiree

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment

(c) The divorce or legal separation or termination of domestic partnership of a covered Employee or Retiree from the Employee's or Retiree's Spouse or domestic partner

(d) A covered Employee's entitlement to Medicare, unless Medicare eligibility is due to End Stage Renal Disease (ESRD)

(e) An Eligible Dependent child's ceasing to satisfy the Plan's definition of an Eligible Dependent child (e.g., attainment of the maximum age for dependency under the Plan)

(f) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to the Plan Sponsor which results in a loss of coverage for a Retiree and/or a Retiree's covered Dependents.

If the Qualifying Event causes the covered Employee , or the Spouse or an Eligible Dependent child of the covered Employee or Retiree, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met.

The taking of leave under the FMLA does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA Leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA Leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) The covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA Leave.

A voluntary waiver of coverage by an Employee on behalf of the Employee or on behalf of an Eligible Dependent, such as during an open enrollment period, is not a Qualifying Event.

(3) Election Periods

To be eligible for COBRA coverage, a Qualified Beneficiary must make a timely election. An election is timely if it is made during the election period. The election period begins no later than the date the Qualified Beneficiary loses coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary loses coverage on account of the Qualifying Event or the date the Qualified Beneficiary is notified of the right to elect COBRA continuation coverage.

(4) Informing the Plan Administrator of the Occurrence of a Qualifying Event

In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Retiree or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

(a) An Eligible Dependent child ceasing to be an Eligible Dependent child under the generally applicable requirements of the Plan

(b) The divorce or legal separation or termination of domestic partnership of the covered Employee or Retiree

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

(5) Revoking a Waiver of Coverage during the Election Period

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

(6) Termination of COBRA continuation coverage

Except for an interruption of coverage in connection with the revocation of a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(a) The last day of the applicable maximum COBRA coverage period

(b) The first day for which Timely Payment (as defined below) is not made to the Plan with respect to the Qualified Beneficiary

(c) The date upon which the Employer ceases to provide any group health plan (including successor plans)

(d) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary

(e) The date, after the date of the election, that the Qualified Beneficiary is entitled to Medicare benefits (either part A or part B, whichever occurs earlier)

(f) In the case of a Qualified Beneficiary entitled to a disability extension (as described below), the later of:

(i) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(ii) The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

In the case of an Employee or Eligible Dependent who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the Employee's or Eligible Dependent's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the Employee or Eligible Dependent who is not a Qualified Beneficiary.

(7) Maximum COBRA coverage periods

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is no disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a covered Employee's entitlement in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(i) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(ii) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment

(c) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving

Spouse or Eligible Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.

(d) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(e) In the case of any Qualifying Event other than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

(8) Limited circumstances under which the maximum coverage period can be expanded

If a Qualified Beneficiary experiences a second Qualifying Event while receiving 18 months of COBRA continuation coverage, the Employee's or Retiree's Spouse, surviving Spouse or Eligible Dependent children can get up to 18 additional months of COBRA continuation coverage, for maximum coverage of 36 months, if notice of the second Qualifying Event is properly given to the Plan Administrator. This extension is available to the Spouse and any Eligible Dependent children receiving continuation coverage if the Employee or Retiree or former Employee, or former Retiree dies, gets divorced or legally separated, if the Employee or former Employee's domestic partnership is terminated or if the Eligible Dependent child stops being eligible under the Plan as an Eligible Dependent child, but only if the event would have caused the Spouse or Eligible Dependent children to lose coverage under the Plan had the first Qualifying Event not occurred. In all of these cases, the Qualified Beneficiary must notify the Plan Administrator of the second Qualifying Event within 60 days of the Qualifying Event.

(9) Disability extensions of coverage

A disability extension will be granted in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, if a Qualified Beneficiary (whether or not a covered Employee) is determined under Title II or XVI of the Social Security Act to have been disabled at some time before the 60th day of COBRA continuation coverage. The disability must last at least until the end of the 18-month period of continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage period.

(10) Payment for COBRA Continuation Coverage

For any period of COBRA continuation coverage, the Plan requires the payment of an amount that equals 102% of the applicable premium, unless the Plan requires the payment of an amount that equals 150% of the applicable premium for any period of COBRA continuation coverage based on a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that Qualified Beneficiary.

Payments for COBRA continuation coverage may be made in monthly installments or may be made for multiple months in advance.

(11) Timely Payment for COBRA Continuation Coverage

Timely Payment for a period of COBRA coverage means payment that is made to the Plan by 30 days after the first day of that period. Notwithstanding the above, a Qualified Beneficiary has 45 days after the date of the election of COBRA continuation coverage to make the initial payment for coverage. The initial payment for coverage must include payment for the entire period that begins on the date of the Qualifying Event (or revocation of waiver) and ends on the last day of the month in which the initial payment is submitted. Payment is considered made on the date on which it is sent to the Plan.

(12) COBRA Coverage for Employees in the Uniformed Services

For purposes of this Article, an Employee who is absent from work for more than 31 days in order to fulfill a period of duty in the Uniformed Services will experience a Qualifying Event as of the first day of the Employee’s absence for such duty. Such an Employee and any of the Employee’s covered Eligible Dependents will be treated as any other Qualified Beneficiary under Section B, item 1 for all purposes of COBRA. However, to the extent that the Uniformed Services Employment and Reemployment Rights Act (“USERRA”) provides greater continuing coverage rights, the provisions of USERRA will apply. The Plan Administrator will furnish the Employee and the Employee’s covered Eligible Dependents a notice of the right to elect COBRA continuation coverage (as provided above) and shall afford the Employee the opportunity to elect such coverage. However, the maximum period of coverage available to the Employee and the Employee’s Eligible Dependents under USERRA is the lesser of (a) 24 months beginning on the date of the Employee’s absence or (b) the day after the date on which the Employee fails to apply for or return to active employment from active duty under USERRA with the Employer. If the leave is thirty (30) days or less, the contribution rate will be the same as for active Employees. If the leave is longer than thirty (30) days, the required contribution is 102% of the cost of coverage.

XI. HIPAA PRIVACY AND SECURITY

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal law that governs the use and disclosure of protected health information ("PHI") by group health plans and provides rights to Covered Persons with respect to their PHI.

There are three (3) circumstances under which the Plan may disclose a Covered Person's PHI to the Plan Sponsor.

First, the Plan may inform the Plan Sponsor whether a Covered Person is enrolled in the Plan.

Second, the Plan may disclose summary health information to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims experienced by Covered Persons and may identify the Covered Person.

Third, the Plan may disclose PHI to the Plan Sponsor for Plan administrative purposes. This is because Employees of the Plan Sponsor perform many of the administrative functions necessary for the management and operation of the Plan.

In order for the Plan Sponsor to receive and use PHI, the Plan Sponsor has certified to the Plan that the Plan Sponsor agrees to:

(1) Only use or disclose PHI for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. A description of how the Plan uses and discloses PHI and Covered Persons rights under HIPAA are described in the Plan's Notice of Privacy Practices. The Notice of Privacy Practices is provided upon enrollment and periodically thereafter in accordance with applicable requirements; it can be accessed any time at www.hpiTPA.com;

(2) Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(3) Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Plan Sponsor;

(4) Promptly report to the Plan any use or disclosure of PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

(5) Make PHI available to a Covered Person in accordance with HIPAA;

(6) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(7) Make available the information required to provide an accounting of disclosures in accordance with HIPAA;

(8) Make its internal practices, books, and records, relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with HIPAA;

(9) If feasible, return or destroy all PHI received from or on behalf of the Plan that Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed to administer the Plan. If return or destruction is not feasible, the Plan Sponsor will limit further use or disclosure to those purposes that make return or destruction of the information infeasible;

(10) Ensure there is adequate separation between the Plan and the Plan Sponsor, as required by HIPAA (45 C.F.R. §164.504(f)(2)(iii)) and described below, and that such separation is supported by reasonable and appropriate security measures:

(a) In addition to the Privacy Officer, the following Employee(s) or class(es) of Employees or other persons under the control of the Plan Sponsor ("Workforce Members") may be given access to PHI, to the extent that such access and use is restricted to plan administration functions that the Plan Sponsor performs for and on behalf of the Plan:

- Senior Director of Human Resources
- Assistant Director of Human Resources
- Benefits Manager
- Employees and other workforce members at the direction of the above listed classes of employees
- Benefits Analyst
- Employee Health Coordinator

(b) If the Plan Sponsor becomes aware of any Employee or Workforce Member's use or disclosure of PHI in violation of HIPAA or this Plan Document, the Plan Sponsor will promptly report the violation to the Plan and will cooperate with the Plan to address the violation, to impose appropriate sanctions, and to mitigate any harmful effects to a Covered Person.

(11) Implement appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;

(12) Require that any agent or subcontractor to whom it provides PHI agrees to implement reasonable and appropriate security measures to protect the information;

(13) Report to the Plan any security incident that the Plan Sponsor becomes aware of; and

(14) Maintain adequate separation between the Plan and itself.

XII. THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT PROVISIONS

A. Payment Condition

(1) The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of a Covered Person, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

(2) Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person(s) shall be a trustee over those Plan assets.

(3) In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

(4) If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

B. Subrogation

(1) As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to pursue said rights and/or obligations.

(2) If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Injury, Illness, disease or disability to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person(s) is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person(s) is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

(3) The Plan may, at its own discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

(4) If the Covered Person(s) fails to file a claim or pursue damages against:

(a) The responsible party, its insurer, or any other source on behalf of that party;

(b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state;

(c) Any policy of insurance from any insurance company or guarantor of a third party;

(d) Worker's compensation or other liability insurance company; and/or,

(e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

C. Right of Reimbursement

(1) The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person's(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person(s) are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's(s') obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person(s) is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

(2) No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

(3) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or

other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

(4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

(5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Injury, disease or disability

D. Covered Person is a Trustee Over Plan Assets

(1) Any Covered Person(s) who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury, Illness, disease or disability. By virtue of this status, the Covered Person(s) understands that he/she is required to:

(a) Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

(b) Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

(c) In circumstances where the Covered Person(s) is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person(s) obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

(d) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

(2) To the extent the Covered Person(s) disputes this obligation to the Plan under this section, the Covered Person(s) or any of his/her agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

(3) No Covered Person(s), beneficiary, or the agents or representatives thereof, exercising control over Plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

E. Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) (Incurred) prior to the liable party being released from liability. The Covered Person's/Covered Persons' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

F. Excess Insurance

If at the time of Injury, Illness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to any of the following:

(1) The responsible party, its insurer, or any other source on behalf of that party;

(2) Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage under a different name in a particular state;

(3) Any policy of insurance from any insurance company or guarantor of a third party;

(4) Worker's compensation or other liability insurance company; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

G. Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

H. Wrongful Death

In the event that the Covered Person(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

I. Obligations

(1) It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

(a) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

(b) To provide the Plan with pertinent information regarding the Injury, Illness, disease, or disability, including accident reports, settlement information and any other requested additional information;

(c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

(d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

(e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;

(f) To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan;

(g) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

(h) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person(s) may have against any responsible party or Coverage;

(i) To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;

(j) In circumstances where the Covered Person(s) is not represented by an attorney, instruct the insurance company or any third party from whom the

Covered Person(s) obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and

(k) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person(s) over settlement funds is resolved.

(2) If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury, Illness, disease or disability, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

(3) The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person(s)' cooperation or adherence to these terms.

J. Offset

If timely repayment is not made, or the Covered Person(s) and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person(s)' amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person(s) to the Plan. This provision applies even if the Covered Person(s) has disbursed settlement funds.

K. Minor Status

(1) In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

(2) If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

L. Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights

with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

M. Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

N. Definitions

For purposes of this Article XII, the following words and phrases will have the following meanings when used in the Plan under this Article XII, unless a different meaning is plainly required by the context.

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

XIII. AMENDMENT AND TERMINATION OF PLAN

A. Amendment

The Employer has the right to amend this Plan in any and all respects at any time, and from time to time, without prior notice.

Any such amendment will be by a written instrument signed by a duly authorized Officer of the Employer.

The Plan Administrator will notify all Covered Persons of any amendment modifying the material terms of the Plan as soon as is administratively feasible after its adoption, but in no event later than 210 days after the close of the Plan Year in which the amendment has been adopted. Such notification will be in the form of a Summary of Material Modifications unless incorporated in an updated Summary Plan Description.

Notwithstanding the above, to the extent the material change is a material reduction in Covered Services or benefits, such Summary of Material Modifications shall be distributed within 60 days of the date of adoption of such change.

B. Termination of Plan

Regardless of any other provision of this Plan, the Employer reserves the right to terminate this Plan at any time without prior notice. Such termination will be evidenced by a written resolution of the Employer. The Plan Administrator will provide notice of the Plan's termination as soon as is administratively feasible, but no more than 210 days after the last day of the final Plan Year.

C. Termination by Dissolution, Insolvency, Bankruptcy, Merger, etc.

This Plan will automatically terminate if the Employer (1) is legally dissolved; (2) makes any general assignment for the benefit of its creditors; (3) files for liquidation under the Bankruptcy Code; (4) merges or consolidates with any other entity and it is not the surviving entity; (5) sells or transfers substantially all of its assets; or (6) goes out of business, unless the Employer's successor in interest agrees to assume the liabilities under this Plan as to the Covered Persons.

XIV. GENERAL PROVISIONS

A. Company Funding

All benefits paid under this Plan shall be paid in cash from the general assets of the Employer. No Employees shall have any right, title, or interest whatever in or to any investment reserves, accounts, or funds that the Employer may purchase, establish, or accumulate to aid in providing benefits under this Plan. Nothing contained in this Plan, and no action taken under its provisions, shall create a trust or fiduciary relationship of any kind between the Employer and an Employee or any other person. Neither an Employee nor a beneficiary of an Employee shall acquire any interest greater than that of an unsecured creditor.

B. In General

Any and all rights provided to any person under this Plan shall be subject to the terms and conditions of the Plan. This Plan shall not constitute a contract between the Employer and any Covered Person, nor shall it be consideration or an inducement for the initial or continued employment of any Employee. Likewise, maintenance of this Plan shall not be construed to give any Employee the right to be retained as an Employee by the Employer or the right to any benefits not specifically provided by the Plan.

C. Waiver and Estoppel

No term, condition, or provision of this Plan shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Employee or eligible Beneficiary other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

D. Effect on Other Benefit Plans

Amounts credited or paid under this Plan shall not be considered to be compensation for the purposes of a qualified pension plan maintained by the Employer. The treatment of the amounts paid under this Plan under other Employee benefit plans shall be determined under the provisions of the applicable Employee benefit plan.

E. Nonvested Benefits

Nothing in this Plan shall be construed as creating any vested rights to benefits in favor of any Employee or Eligible Dependent.

F. Interests not Transferable

The interests of the Employee and their Eligible Dependents under this Plan are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, alienated, assigned or encumbered without the written consent of the Plan Administrator.

G. Severability

If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Employer shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

H. Headings

All Article and Section headings in this Plan have been inserted for convenience only and shall not determine the meaning of the content thereof.

I. Limitations on Actions

Any legal action against the Plan must be brought within three (3) years of the initial denial of any benefit.

XV. CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS

Claims and Appeals Procedures

This section describes a Covered Person's rights and obligations with respect to filing claims, receiving timely notice about whether and the extent to which benefits are payable, and the option to appeal a claim that has been denied in whole or in part.

Designating an Authorized Representative

For initial claims
For the purposes of filing initial claims for coverage under the Plan, the health care provider who rendered services to the Covered Person is deemed to be an authorized representative, and most claims are filed by health care providers directly with Quantum Health. The Covered Person may also designate another person to be the authorized representative for filing claims and should contact Quantum Health at (866) 360-7926 for assistance with the necessary paperwork.. After an authorized representative has been designated, all subsequent notices and decisions concerning claims will be provided to the Covered Person through his or her authorized representative. Claims are subject to the filing limits described in this Article.

For appeals or requests for external review
For the purposes of filing appeals or requesting external review of denied Urgent Care Claims (defined below) on behalf of a Covered Person, the Covered Person's treating health care provider is deemed to be an authorized representative. The Covered Person may also name another individual as an authorized representative for appeals and external review, as well as for a health care provider to appeal or request review of a non-Urgent Care Claim on behalf of the Covered Person, by contacting the PAE at (866) 360-7926 for further assistance. After an authorized representative has been designated, all subsequent notices and decisions concerning appeals or requests for external review will be provided to the Covered Person through his or her authorized representative.

Exhaustion of Internal Appeals Required

Under this Plan, there are two levels of mandatory internal appeals. A Covered Person is required to exhaust both levels of the internal appeals process before requesting an external review or pursuing other legal remedies that may be available except in the following situations: 1. In cases involving Urgent Care Claims, the Covered Person may forego the internal appeals process and request an expedited external review upon receipt of the initial claim denial and 2. In cases where the Plan has not adhered to the claims and appeals requirements specified in this Plan and the violation is more than *de minimis*, the internal review process may be deemed to be exhausted and the Covered Person may initiate an external review or take other available legal action. Appeals, requests for external review and other legal actions are subject to the filing periods described in this Article and the *General Provisions/Limitations on Actions* section of this Plan Document.

Claims and Appeals Overview

The Plan Administrator has delegated the administration of claims processing under the Plan to the Claim Administrator. As directed by the Plan Administrator: i) the Claim Administrator makes initial claim determinations for Post-Service Claims based on the specific terms of the Plan; ii) for prescription claims, the Prescription Benefit Manager makes initial claim and first and second level appeal determinations based on the specific terms of the Plan; iii) the PAE makes initial claim determinations for Urgent Care, Concurrent Care and Pre-Service Claims based on the specific terms of the Plan; and iv) the PAE makes first and second level appeal determinations for Urgent Care, Concurrent Care, Pre-Service and Post-Service Claims based on the specific terms of the Plan.

The steps involved in claims and appeals processing are outlined below. Important details about the required procedures and Covered Persons' rights are included in Sections A-F below.

(1) All initial claims must be filed within one (1) year of the Expense Incurred Date (as defined in the Article titled "Definitions" of this Plan Document).

(2) As directed by the Plan Administrator, and as set forth above, either the Claim Administrator, the Prescription Benefit Manager, or the PAE will make an initial determination about benefits payable based on the specific terms of the Plan and will notify the Covered Person within the period specified for the type of claim filed (see *D. Initial Claim Determination*, and Chart A, below).

(3) If the claim is denied in whole or in part, it is called an adverse benefit determination. An adverse benefit determination includes a "rescission" (retroactive termination) of an individual's coverage under the Plan due to fraud or intentional misrepresentation. If the Covered Person disputes the determination, he or she may contact the PAE, or for prescription claims the Prescription Benefit Manager, to confirm that the claim was properly processed, or may file a formal internal appeal (see *F. Internal Appeals and External Review of Denied Claims*, below). Note that in cases of Urgent Care Claim denials based in whole or in part on medical judgment, the Covered Person may forego the internal appeals process and request an expedited external review (*see 6 below*).

(4) As directed by the Plan Administrator, the PAE, or for prescription claims the Prescription Benefit Manager, will review the first internal appeal and will make an appeal determination based on the specific terms of the Plan within the period specified for the type of claim that is the subject of the appeal (see *F. Internal Appeals and External Review of Denied Claims*, Chart B below).

(5) If the first internal appeal is denied, the Covered Person may file a second internal appeal with the PAE, or for prescription claims the Prescription Benefit Manager, within the time periods specified in Chart B, below. In cases of Urgent Care Claim denials based in whole or in part on medical judgment, the Covered Person may forego the second internal appeal and request an expedited external review (see 6 below). The appeal will be reviewed by the PAE, who holds the authority to make the final determination about benefits payable under the Plan. The second

appeal is the final internal appeal required (except as described under *Exhaustion of Internal Appeals Required* above) and available under the Plan.

(6) If the final internal appeal is denied in whole or in part and the denial is related to a rescission; based on medical judgment; related to compliance with the No Surprises Act of the Consolidated Appropriations Act of 2021; or if the initial denial was for an Urgent Care Claim (all of the aforementioned reasons are individually referred to in this section as an "External Review Claim" and collectively referred to as "External Review Claims"), the Covered Person (or authorized representative) has the right to request an external review by an independent review organization (IRO) within the time periods specified in Chart B, below. The IRO will review the denial and issue a final decision within the period specified for the type of claim that is the subject of the review. The Covered Person may also elect to take legal action as may be available under state or federal law instead of or following external review, provided such action is initiated within the time period described under the *General Provisions/Limitations on Actions* section of this Plan Document.

A. Who May File a Claim

A Covered Person's health care service provider may submit claims, and most claims are submitted by providers directly to Quantum Health. Alternatively, a claim may be filed by a Covered Person, or by his or her authorized representative. See *Designating an Authorized Representative*, above. After an authorized representative has been designated, all subsequent notices and decisions concerning claims will be provided to the Covered Person through his or her authorized representative.

B. Types of Claims

The time limits applicable to claims and appeals depend on the type of claim at issue. The categories of potential claims are defined below.

(1) Urgent Care Claim – a claim for medical care or treatment where using the time periods allowed or making non-Urgent Care Claim determinations (a) could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that could not be adequately managed without the care or treatment being claimed

(2) Concurrent Care Claim – a claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim

(3) Pre-Service Claim – a claim for a benefit that requires approval (usually referred to as precertification or preauthorization) under the Plan in advance of obtaining medical care

(4) Post-Service Claim – a claim for services that have already been provided or that do not fall into any of the categories above

C. When and How to File a Claim

An initial claim for inpatient benefits must be submitted by the Covered Person, or by the Covered Person's health care provider or other authorized representative, no later than one (1) year after the discharge date or the date coverage under this Plan ends, whichever occurs first. For outpatient benefits, claims must be submitted no later than one (1) year after the date that services are provided. Claims received after that date will be denied. This time limit does not apply if the Covered Person is legally incapacitated.

How a claim may be filed depends on the type of claim:

(1) *Urgent Care Claims, including Urgent Concurrent Care Claims,* may be submitted by calling the PAE at (866) 360-7926 or by any method available for Non-Urgent Care Claims and Pre-Service Claims.

(2) *Non-Urgent Care and Pre-Service Claims* may be submitted verbally by calling the PAE at (866) 360-7926. Such claims may also be filed electronically or using a written form available from the PAE, and must be submitted to the PAE using one of the following methods:

- Electronically
- Hand delivery
- Facsimile (FAX): (877) 498-3681
- U.S. Mail:
  Quantum Health Care Coordinators
  Appeals Department
  7450 Huntington Park Drive, Suite 100
  Columbus, OH 43235
  (866) 360-7926

(3) *Post-Service Claims* may be filed electronically or using a written form available from the Claim Administrator, and must be submitted to the Claims Administrator using one of the following methods:

- Electronically
- U.S. Mail
- Hand delivery
- Facsimile (FAX): (508) 329-4812

Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581	**Mailing Address:** Health Plans, Inc. P.O. Box 5199 Westborough, MA 01581

D. Initial Claim Determination

After a claim has been submitted to either the Claim Administrator, the Prescription Benefit Manager, or the PAE, as set forth above under *Claims and Appeals Overview*, the Plan will make a determination within specified time limits, depending on the type of claim. In some cases, the time limits may be extended if there are circumstances beyond the Claim Administrator's, Prescription Benefit Manager's, or the PAE's control that require a delay, or if the claim was submitted improperly or lacked information necessary to make a determination. In such cases, the Covered Person will be notified about the need for a delay or for additional information regarding the claim within a specified period of time.

The following table shows the applicable time limits based on type and specific circumstances of the claim.

CHART A – Time Limits Regarding Initial Claims				
Type of Initial Claim	**Maximum period after receipt of claim for initial benefits determination**	**Maximum extension of initial benefits determination for delays beyond the control of Quantum Health or the Claim Administrator**	**Maximum period to notify Covered Person of improperly filed claim or missing information**	**Period for Covered Person to provide missing information**
URGENT CARE CLAIMS (not including Urgent Concurrent Care Claims)	72 hours	No extension permitted	24 hours	48 hours minimum*
URGENT CONCURRENT CARE CLAIMS**	24 hours	No extension permitted	24 hours	48 hours minimum*
NON-URGENT CONCURRENT CARE AND PRE-SERVICE CLAIMS	15 days	15 days	15 days	45 days maximum
POST-SERVICE CLAIMS	30 days	15 days	30 days	45 days maximum

*A determination will be made within 48 hours of receiving both a properly filed claim and any missing information.
**Provided the claim is received at least 24 hours before the end of the previously approved course of treatment. Otherwise, the time limits are the same as for Urgent Care Claims.

E. How Claims are Paid

If a claim is approved, in whole or in part, and a Covered Person has authorized payments to a provider in writing, all or a portion of any eligible expenses due to a provider will be paid directly to the provider; otherwise payment will be made directly to the Covered Person. Third parties who have purchased or been assigned benefits by Physicians or other providers will *not* be reimbursed directly by the Plan. An Assignment of Benefits does not grant the provider any rights other than those specifically set forth herein.

F. Internal Appeals and External Review of Denied Claims

If a claim is denied in whole or in part, a Covered Person may file an internal appeal of the adverse benefit determination. In making an appeal or request for external review, the Covered Person has the right to designate an authorized representative to act on the Covered Person's behalf for the purposes of the appeal or request for external review. See *Designating an Authorized Representative* at the beginning of this section.

Before filing an appeal, a Covered Person may first want to contact the PAE for medical claims or the Prescription Benefit Manager for prescription drug claims at the phone number(s) as shown below in (3) *How and Where to Submit Appeals* to verify that the claim was correctly processed under the terms of the Plan, however, the Covered Person is not required to do so.

Initial internal appeals must be filed within 180 days of the initial claim denial; second internal appeals must be filed within 60 days of the initial appeal denial; requests for external review (available for External Review Claims) must be filed within 4 months of the second internal appeal denial, or in cases involving Urgent Care, may be filed upon receipt of the initial claim denial. Any appeal or request for external review received after these deadlines will be denied. Chart B below shows details of the deadlines for filing appeals and making determinations upon review.

How initial and second internal appeals or requests for external review (if applicable) can be filed depends on the type of appeal or request for external review:

(1) *Urgent Care Claim appeals or requests for external review* may be submitted either verbally or in writing by calling or faxing the PAE for medical claims or verbally by calling the Prescription Benefit Manager for prescription claims as shown below in (3) *How and Where to Submit Appeals*. Upon request, Urgent Care Claim denials based on a medical judgment may be submitted for external review either upon receipt of the initial claim denial, after the first internal appeal or after completing the internal appeals process.

(2) *Non-Urgent Care, Pre-Service and Post-Service Claim appeals or requests for external review* for medical claims may be submitted either verbally or in writing by calling or contacting the PAE as shown below in (3) *How and Where to Submit Appeals*.

(3) *How and Where to Submit Appeals*

Urgent Care Claim, Non-Urgent Care Claim and Post-Service Claim appeals or requests for external review may be submitted to the PAE or the Prescription Benefit Manager using one of the following methods:

Medical Appeals	
Quantum Health Care Coordinators Appeals Department 7450 Huntington Park Drive, Suite 100 Columbus, OH 43235 Phone #: (866)-360-7926	**Method:** ▪ Telephone ▪ U.S. Mail ▪ Hand delivery ▪ Facsimile (FAX): (877) 498-3681
Prescription Inquiries/Prior Authorization/Appeals	
Covered Persons should contact the Prescription Benefit Manager directly at the telephone number listed on his/her ID card for directions on submitting appeals.	

Written appeals and requests for external review *must* include the following information:

(1) The patient's name

(2) The patient's Plan identification number

(3) Sufficient information to identify the claim or claims being appealed, such as the date of service, provider name, procedure (if known) and claim number (if available)

(4) A statement that the Covered Person (or authorized representative on behalf of the Covered Person) is filing an appeal or request for external review

In making an appeal or request for external review, the Covered Person has the right to:

- Review pertinent documents and submit issues and comments in writing.
- Request the billing and diagnosis codes related to the claim if the Covered Person believes a coding error may have caused the denial.
- Automatically receive any new or additional evidence or rationale considered, relied upon or generated by the Plan in connection with the claim as soon as possible so as to provide the Covered Person with reasonable time to respond before the final internal determination is issued.
- Designate an authorized representative to act on the Covered Person's behalf for the purposes of the appeal or request for external review.
- Submit written comments, documents, records, or any other matter relevant to the appeal or request for external review, even if the material was not submitted with the initial claim.
- Have reasonable access to, and copies of, all documents, records, and other information relevant to his or her appeal or request for external review, upon request and free of charge.

All appeals or requests for external review will be given a review that takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the appeal or request for external review, regardless of whether such information was submitted or considered in the initial benefit determination. In addition, the review will not afford deference to the initial adverse benefit determination, and the review decision will be made by individuals who were not involved in the initial claim denial and who are not subordinates of those who made the initial determination. If the denial was based on a medical judgment, the appeal or request for external review will be reviewed by a health care professional retained by the Plan who did not participate in the initial denial.

If the initial appeal is denied, the Covered Person will be given the specific reasons for the denial, with reference to the applicable Plan provision, rule, guideline, protocol or criteria upon which the denial was based. In the event that an initial appeal is denied, the Covered Person will have 60 days to request a second appeal. Alternatively, in cases involving Urgent Care Claim denials based on medical judgment, a Covered Person may forego the second internal appeal and request an external review. In filing a second appeal, the Covered Person must follow the procedures specified above, and will have the same rights as specified for the initial appeal. The second appeal will be reviewed by the PAE who holds authority under the Plan to make factual findings and to interpret Plan provisions regarding the payment of benefits for such claims**.**

If the second appeal is denied, the Covered Person will be given the specific reasons for the denial, with reference to the applicable Plan provision, rule, guideline, protocol or criteria upon which the denial was based. In the event that a second appeal is denied, and the denial involved an External Review Claim, the Covered Person will have 4 months to request an external review. In filing a request for an external review, the Covered Person must follow the procedures specified above, and will have the same rights as specified for the initial and second appeal. The PAE will conduct a preliminary review of the request to determine if the claim is eligible for external review and will provide timely notification to the Covered Person, in accordance with the requirements of federal law, as to whether the claim is eligible and whether any additional information is needed if the request is incomplete. If the claim is eligible for external review, the PAE will assign the review to an IRO on a random basis, rotating assignments among IROs. The IRO will review the Plan's denial "de novo" and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO's determination will be binding on the Plan and the Covered Person, except to the extent that other remedies are available under state or federal law. If the IRO overturns the Plan's denial, the Plan will provide coverage or payment for the services regardless of whether the Plan intends to seek other remedies available under state or federal law.

For appeals of denials based on reasons other than an External Review Claim, the second internal appeal is the final appeal available to the Covered Person and there is no further review available under the Plan. However, Covered Persons may have other remedies available under state or federal law, such as filing a lawsuit.

Any legal action against the Plan must be brought within the time periods described under the *General Provisions/Limitations on Actions* section of this Plan Document.

CHART B – Time Limits Regarding Initial and Internal Second Appeals and Request for External Review						
Type of Claim	**Maximum period for Covered Person to file initial internal appeal after initial denial**	**Maximum period for issuing determination regarding initial appeal**	**Maximum period for Covered Person to file second internal appeal following denial of initial appeal in whole or in part**	**Maximum period for issuing determination regarding second appeal**	**Maximum period for Covered Person to file request for external review following denial of final appeal***	**Maximum period for issuing determination regarding external review**
URGENT CARE CLAIMS (including Urgent Concurrent Care Claims)	180 days	72 hours for both initial determination and expedited external review, if eligible and requested	60 days	72 hours	For denials involving medical judgment, Covered Persons may request expedited external review upon the initial claim denial, upon the first appeal denial, or may request external review within 4 months of the final internal appeal determination	72 hours
NON-URGENT CONCURRENT CARE AND PRE-SERVICE CLAIMS	180 days	15 days	60 days	15 days	4 months	45 days
POST-SERVICE CLAIMS	180 days	30 days	60 days	30 days	4 months	45 days

*available for External Review Claims

Statement of Rights

Participants in this Plan are entitled to certain rights and protection. All Plan participants will be entitled to:

(1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents governing the Plans including insurance contracts and collective bargaining agreements (if any);

(2) Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan including insurance contracts and collective bargaining agreements, 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 if the Plan is required to distribute such a summary annual financial report; and

(4) Continue health care coverage for himself or herself, Spouse, or dependents if there is a loss of coverage under the Plan as a result of a COBRA Qualifying Event. The individual or his or her dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing his or her COBRA continuation coverage rights.

No one, including his or her employer, his or her union (if any), or any other person, may fire the individual or otherwise discriminate against the individual in any way to prevent the individual from obtaining benefits under the Plan.

If his or her claim for a benefit under this Plan is denied in whole or in part the individual must receive a written explanation of the reason for the denial. The individual has the right to have the Plan review and reconsider his or her claim.

If the individual has a claim for benefits that is denied or ignored, in whole or in part, the individual may be able to request an external review or file suit in a state or federal court after exhausting the internal appeals process described in this Article. There may be exceptions to the requirements that individuals exhaust the internal appeals process before seeking external review or pursuing legal remedies if the Plan does not adhere to the procedural standards for claims and appeals described under this Article in a manner which is compliant with the Patient Protection and Affordable Care Act.

Any legal action against the Plan must be brought within the time periods described in the General Provisions/Limitations on Actions section of this Plan Document.

If the individual has any questions about this Plan, the individual should contact the Plan Administrator.

IN WITNESS WHEREOF, the Employer has caused this The City of Savannah Employee Group Medical Plan Document – TCN to be executed by its duly authorized representative.

The City of Savannah

May 27, 2022
Date

By: Jeffery Grant
Jeffery Grant (May 27, 2022 16:24 EDT)
Authorized Signature

Jeff Grant
Print Name

Human Resources Director
Title