BARTON COUNTY COMMUNITY COLLEGE LEVEL II PREVENTIVE HEALTH BENEFITS PLAN

Summary Plan Description

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SUMMARY PLAN DESCRIPTION

This Summary Plan Description ("SPD") describes the basic features of the Barton County Community College Level II Preventive Health Benefits Plan (the "Plan"). This SPD is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant. The SPD is not a part of the official Plan document. The SPD is also distinct from the Plan's Summary of Benefits and Coverage ("SBC"). ***If there is a conflict between the Plan document and this SPD (or, for that matter, the SBC), the Plan document will control.***

I. General Information

(A) ***Plan Sponsor.*** The name, address, telephone number, and Federal tax identification number of the Plan Sponsor are:

BARTON COUNTY COMMUNITY COLLEGE
245 NE 30 ROAD
GREAT BEND, KS 67530
(620) 792-9275
EIN: 48-0720175

(B) ***Employer.*** References to the "Employer" in this SPD mean, collectively, the Plan Sponsor and all Participating Plan Sponsors (if any).

(C) ***Named Fiduciary.*** The named fiduciary of the Plan is the Plan Sponsor.

(D) ***Claims Administrator.*** The Claims Administrator is Benefit Management, LLC. Benefit Management does not serve as an insurer, but merely as a claims processor. After claims for benefits are sent to Benefit Management, it processes the Claims and then requests and receives funds from the Plan Sponsor in order to make payment on the Claims to providers.

(E) ***Identification of Plan.*** The name of the Plan is the Barton County Community College Level II Preventive Health Benefits Plan (the "Plan").

(F) ***Plan Year / Benefit Year.*** The Plan Year, which refers to the period on which the Plan maintains its records, is November 1 through October 31. The Benefit Year, which refers to the period on which Claims will be paid under the Plan, is the same as the Plan Year.

(G) ***Effective Date of Plan.*** The Effective Date of this restated Plan is November 1, 2017.

(H) ***Type of Plan.*** The Plan is a self-funded group health plan. The Plan is funded by the Employer; however, benefit Claims are processed by the Claims Administrator. Preventive benefits will be provided through this Plan.

(I) ***Plan Administrator.*** The Plan Sponsor serves as the Plan Administrator in this Plan. The Plan Administrator is responsible for making sure that the Plan is administered according to its terms, for providing you and other participants with information about the Plan, for resolving any questions about participant eligibility and participant benefits, and for making any other discretionary determinations that need to be made in order for the Plan to function.

(J) ***Service of Process.*** The name of the person designated as the Agent for Service of Legal Process is Mark Dean, Vice President of Administration, whose address is the same as the Employer's address. In addition, service of process may be made upon the Plan Administrator at the address listed above for the Plan Sponsor.

II. Eligibility to Participate in the Plan

You will automatically become a Participant in the Plan on your Plan entry date if you satisfy the eligibility conditions for the Plan. Once you become a Participant, you will continue to be a Participant until the eligibility conditions are no longer met. These requirements are explained in more detail below.

(A) ***Eligible Individuals.*** You are eligible to participate in the Plan if you are:

(1) An Employee of the Employer.

(B) ***Excluded Individuals.*** You are not eligible to participate in this Plan under any circumstances if you are working for the Employer in any of the following capacities:

(1) Employees covered by a collective bargaining agreement.

(2) "Leased employees," as that term is used in Section 414(n) of the Internal Revenue Code.

(3) **Other:** Student Employees and Employees who are enrolled in the Barton County Community College Employee Health Care Plan.

(C) ***Eligible Dependents.*** Your Dependents are eligible to participate in the Plan if they meet at least one of the following conditions:

(1) Spouse.

- Note that, for purposes of this Plan, a Spouse is a person of the same or opposite sex to whom you are legally married under the laws of the State in which the marriage was entered into, regardless of where you are currently living. A person will not be considered your Spouse under this Plan if (a) the marriage has been legally terminated by a court having jurisdiction over the marriage, (b) he/she is legally separated from you, or (c) either party to the marriage is legally married to another (third) party under the laws recognized by any State.

(2) Children up to age 26.

(3) Children who are older than 26 and disabled.

(D) ***Waiting Period.*** Before you and your Dependents can enter the Plan, you must have completed thirty (30) days of employment with the Employer. You will then enter the Plan on the first day of the first month coincident with or next following the date you have satisfied the Waiting Period.

If you terminate employment with the Employer and are later rehired into a position in which you are eligible to participate in the Plan, you must again satisfy the Plan's Waiting Period before you are able to participate in the Plan.

III. Commencement and Termination of Coverage Under the Plan

(A) ***Enrollment in the Plan.*** To become a Participant in the Plan, you must enroll using the forms provided by the Plan Administrator. These forms must be completed and returned to the Plan Administrator on or before your Plan entry date (or, if later, within the deadline for completing any enrollment materials, as set forth below). *If you do not complete the enrollment materials required by the Plan Administrator, you will not receive any benefits under the Plan.*

(1) *Failure to Enroll When First Eligible*. If you fail to enroll when you are first eligible to do so, you may not enroll in the Plan until the next Open Enrollment Period, in which case your enrollment will not take effect until the first day of the following Plan Year. The same rule applies if you fail to enroll your Dependents when they are first eligible to enter the Plan. In general, you must enroll in the Plan within 63 days of the date on which you first became eligible to participate in the Plan. There are, however, a number of exceptions to this rule, which are set forth below:

(2) *"Special Enrollment" Rights Pursuant to HIPAA.*

(a) Acquisition of New Dependent. If you acquire a new Dependent as a result of marriage, birth, adoption, or appointment of legal guardianship, you may enroll that Dependent outside the normal Open Enrollment Period. To do so, you must enroll them in this Plan (by completing any required enrollment materials) within 63 days of the marriage, birth, adoption, or legal guardianship appointment.

(b) Loss of Other Group Health Plan Coverage. If you declined enrollment in the Plan for yourself and/or your Dependents because you and/or your Dependents were enrolled in another group health plan or health insurance policy, and that other coverage is subsequently lost, you may enroll yourself and/or your Dependents in this Plan outside the normal Open Enrollment Period. To do so, you must enroll in this Plan (by completing any required enrollment materials) within 63 days after your other coverage ends.

(c) Eligibility (or Loss of Eligibility) for Premium Assistance Under Medicaid or SCHIP. If you or your Dependent become eligible for a state premium assistance subsidy under the Plan from either Medicaid or a state's children's health insurance program (SCHIP), or if you or your Dependent lose eligibility for Medicaid or SCHIP, you and/or your Dependent may enroll in the Plan outside the normal Open Enrollment Period. To do so, you must enroll yourself (and/or your Dependent) in this Plan by completing any required enrollment materials) within 63 days of the applicable event.

(d) Special Tag-Along Rule. If you and/or your Dependent(s) enroll in the Plan by virtue of the HIPAA "special enrollment" rights set forth above, any other Dependents who are eligible, but not currently enrolled in the Plan, may enroll at the same time. This is known as the "tag-along" rule adopted by the Plan.

(3) *Qualified Medical Child Support Orders*. The Plan will enroll and provide coverage to any of your Dependents who are the subject of a Qualified Medical Child Support Order ("QMCSO"), consistent with the terms of the QMCSO and any applicable federal laws and regulations. An appropriately completed National Medical Support Notice will be deemed to be a QMCSO for purposes of this Plan. You and your Dependents may obtain

from the Plan Administrator, free of charge, a copy of the Plan's procedures governing the determination of whether an order is a QMCSO.

(B) ***Plan Entry Date for Participants.*** If you have met the Plan's eligibility conditions (including any Waiting Period) and you have completed all of the required enrollment materials, you will enter the Plan on the first day of the month coincident with or next following the completion of the Waiting Period.

EXAMPLE #1. You are hired as a full-time Employee on March 15. You complete thirty (30) days of employment with the Employer on April 13 and you enroll in the Plan using the form(s) provided by the Plan Administrator. You will enter the Plan on the first day of the next month, which is May 1.

However, if you are enrolling in this Plan based on your loss of coverage in another group health plan or insurance policy, then you will enter the Plan on the first day of the month coincident with or next following the date on which the Plan Administrator receives your enrollment materials.

(C) ***Plan Entry Date for Dependents.*** In general, your Dependents (whom you have timely enrolled) will enter the Plan at the same time as you. If you had been participating in the Plan but one or more of your Dependents had not, you may enroll such Dependents during the Open Enrollment Period, at which point their coverage will commence on the first day of the Plan Year. If you wish to enroll a Dependent outside of the Open Enrollment Period based on one of the special enrollment rights described in Section III(A) above, the following rules apply with respect to the Dependent's commencement of coverage under the Plan:

(1) *Newborn and Newly Acquired Children*. If your newborn or newly acquired Child (via adoption or appointment of legal guardianship) is properly enrolled in the Plan, the Child will enter the Plan on:

(a) The date of birth in the case of a natural or adopted newborn Child; or

(b) In the case of a child other than a newborn, the date the child is placed in the Participant's home for adoption, or the date the court awards legal guardianship to the Participant and/or his/her Spouse.

(2) *New Spouse*. If your new spouse is properly enrolled in the Plan, he/she will enter the Plan on the date of the marriage.

(3) *New Dependent Eligibility Based on Loss of Other Group Health Plan Coverage*. If you are enrolling your Dependent in this Plan based on his/her/their loss of coverage in another group health plan or insurance policy, then the Dependent(s) will enter the Plan on the first day of the month coincident with or next following the date on which the Plan Administrator receives the enrollment materials.

(4) *All Other Situations*. For all other situations in which you are permitted to enroll a Dependent outside the normal Open Enrollment Period, the Dependent will enter the Plan on the first day of the month coincident with or next following the date that the Dependent becomes eligible for coverage under the Plan, provided that the Plan Administrator receives the enrollment materials within the time period required by the Plan.

(5) *Special Rule for Dependents Entering Plan Pursuant to Tag-Along Rule*. If a Dependent is being enrolled in the Plan pursuant to the tag-along rule (*see* Section III(A)(2)(d) of this SPD), the Plan may, for administrative convenience, allow such Dependent to enter the Plan at the same time as the Participant and/or other Dependent(s), even if it is earlier than the time that such Dependent would otherwise be permitted to enter the Plan.

(D) ***Termination of Participant's Coverage.*** Your participation in the Plan will end at the end of the last day of the month coincident with or next following your loss of eligibility or termination of employment.

Please note that, while your coverage for benefits under the Plan ends with the termination of your participation, you may be entitled to purchase COBRA continuation coverage.

(E) ***Termination of Coverage of Dependent.*** Your Dependent's participation in the Plan ends at the end of the month coincident or next following the date on which the Dependent ceases to satisfy the eligibility conditions of the Plan.

Please note that, while your Dependents' coverage for benefits under the Plan ends simultaneously with the termination of your participation, your Dependents may be entitled to purchase COBRA continuation coverage.

IV. Continuation Coverage Under the Plan

(A) ***COBRA Continuation Coverage – In General.*** If the coverage for you and/or your eligible Dependent(s) under the Plan terminates because of certain "qualifying events" specified in a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), then you and/or your eligible Dependent(s) may have the right to purchase continuing coverage under the Plan for a limited period of time. COBRA requires that continuation coverage must be offered to "qualified beneficiaries" (described below) who lose their coverage under the Plan as a result of certain "qualifying events" (described below), so long as the qualified beneficiary timely notifies the Plan Sponsor of the "qualifying event" and pays any applicable premiums.

(B) ***Qualified Beneficiaries.*** Under COBRA, "qualified beneficiaries" include you and/or any of your Dependents who were covered under the Plan on the day before the "qualifying event." Qualified beneficiaries also include any children who are born to, or adopted by, you while you are continuing your coverage pursuant to COBRA.

(C) ***Qualifying Events.*** A "qualifying event" includes any of the following occurrences if you (or another qualified beneficiary) would otherwise lose your/their eligibility for coverage under this Plan as a result of such an event:

(1) Termination of your employment (other than for "gross misconduct") or a reduction in the number of hours you normally work;

(2) Your death;

(3) Divorce or legal separation from your covered Spouse;

(4) Entitlement to Medicare (Part A, Part B, or both); or

(5) Covered Dependent no longer satisfies the conditions for being covered as a Dependent under the Plan;

(D) ***Notice Procedures.*** When the qualifying event is a termination of your employment, reduction in hours of your employment, or your death, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Plan Administrator of any of these three qualifying events. **For all other qualifying events, you must notify the Plan Administrator in writing within 60 days after the date on which the qualifying beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. If notice of a qualifying event is not timely made within the 60-day notice period, no COBRA coverage may be elected by any qualified beneficiary.**

(E) ***Election to Continue Coverage.*** Once the Plan Administrator receives *timely* notice that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect continuation coverage. For example, your covered Spouse may elect COBRA even if you do not. COBRA may be elected for one, several, or all of your covered Dependent children who are qualified beneficiaries. You may elect COBRA coverage on behalf of your covered Spouse, and either you or your Spouse may elect COBRA coverage on behalf of your children. For each qualified beneficiary who timely elects COBRA coverage, such coverage will begin on the date that Plan coverage would otherwise have been lost.

(F) ***Premium for COBRA Continuation Coverage.*** A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage along with an additional 2% charge or, with respect to an extension of the maximum coverage period due to a subsequent disability, an additional 50% charge. Premiums must be paid on a timely basis or else COBRA coverage will be terminated.

(G) ***Maximum Coverage Period.*** The maximum period of time for which COBRA continuation coverage will be provided shall be as follows:

(1) *Termination of Employment or Reduction in Hours.* If coverage is lost as a result of your termination of employment or a reduction in your hours, the maximum period of COBRA continuation coverage will be 18 months.

(2) *Disability Extension.* If a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage and the qualified beneficiary notifies the Plan Administrator of such determination (a) within 60 days of such determination and (b) while COBRA continuation coverage is still in effect, the maximum period of COBRA continuation coverage will be 29 months.

(3) *Second Qualifying Event.* If a second qualifying event takes place while coverage is being continued following the original qualifying event and the second qualifying event is other than the termination of your employment or a reduction in your hours, the maximum period of COBRA continuation coverage will be 36 months.

(4) *Any Other Qualifying Event.* The maximum period of COBRA continuation coverage will be 36 months for any qualifying event for which a shorter maximum coverage period is not set forth in this Subparagraph (H).

(5) *Calculation of COBRA Deadlines.* The maximum coverage period shall begin as of the date on which the qualified beneficiary would otherwise lose coverage as a result of the original qualifying event (as opposed to beginning on the date of the qualifying event itself). The deadline for the Employer to notify the Plan Administrator of a qualifying event (if applicable) and the deadline for a qualified beneficiary to notify the Plan of a qualifying event (if applicable) shall also be measured from the date that coverage is lost.

(H) ***Termination of COBRA Continuation Coverage.*** COBRA continuation coverage may be terminated prior to the expiration of the maximum coverage period if any of the following circumstances occur:

(1) *Covered Under Another Group Health Plan*. The qualified beneficiary becomes covered under another group health plan;

(2) *Premium Not Paid*. A required premium is not paid within the applicable deadline (including any applicable grace period);

(3) *Plan is Terminated with No Other Coverage Offered in its Place.* The Employer terminates this Plan and no longer offers coverage under a group health plan to any of its Employees;

(4) *Entitlement to Medicare*. After electing COBRA coverage, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both);

(5) *No Longer Disabled*. During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or

(6) *Other Analogous Reasons for Terminating Coverage*. Coverage would have been terminated under the same circumstances for a Covered Person who is not receiving COBRA continuation coverage (e.g., if the Covered Person engages in fraudulent activities against the Plan).

(I) ***Coverage Provided During COBRA Continuation Period.*** The coverage provided during the COBRA continuation period shall be identical to the coverage provided to similarly situated persons covered under the Plan with respect to whom a qualifying event has not occurred. This includes open enrollment and special enrollment rights. If coverage under the Plan is modified for any group of similarly situated persons, the coverage shall also be modified in the same manner for all qualified beneficiaries who have elected to continue their coverage under COBRA.

V. USERRA Continuation Coverage Under the Plan

USERRA Continuation of Coverage. If you are absent from employment as a result of military service, you have the right to elect continuation coverage for a period of up to twenty-four (24) months if such coverage would otherwise be lost as a result of such military service. Your right to continue coverage is subject to the following:

(1) *Payment of Premium.* You must pay the applicable premium for any USERRA continuation coverage. For a leave of absence for thirty (30) days or less, you will not be required to pay more than what you would have paid had you not been on leave. For a

leave of absence of more than thirty (30) days, you may be required to pay up to 102% of the applicable premium under the Plan.

(2) *Exclusions or Waiting Period Upon Reinstatement.* The Plan may impose a Pre-Existing Condition exclusion or Waiting Period for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, your performance of qualified military service.

(3) *Failure to Apply for Reemployment.* Following completion of your military service, your right to continue coverage under USERRA will end if you do not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).

VI. FMLA Continuation Coverage Under the Plan

(A) ***Continuation of Coverage While on Family and Medical Leave.*** If you take unpaid leave under the Family and Medical Leave Act ("FMLA"), the Employer will, to the extent required by the FMLA, continue to maintain your benefits under the Plan on the same terms and conditions as if you were still an active Participant. If you choose to continue your coverage while you are on a FMLA leave, the Employer will continue to pay its share (if any) of the premiums. However, you will be required, if you choose to continue your coverage, to pay your share of the premiums in one or more of the following ways:

(1) You may pay your share of the premiums with after-tax dollars while you are on FMLA leave.

(2) You may pay all or a portion of your share of the premium prior to your FMLA leave.

(B) ***COBRA Coverage Following FMLA Leave.*** If you take FMLA leave and do not return to work at the end of your FMLA leave, you (and/or your Dependents) may be entitled to elect COBRA continuation coverage following such leave if each of the following is true:

(1) Each individual seeking COBRA continuation coverage was covered under the Plan on the day before your FMLA leave began (or became covered during your FMLA leave);

(2) You did not return to employment with the Employer following your FMLA leave; and

(3) You (and your Dependents, as applicable) would, in the absence of COBRA coverage, lose coverage under the Plan within 18 months of your last day of FMLA leave.

If the elements set forth above are satisfied, you (and/or your Dependents) will be eligible to seek COBRA continuation coverage following your FMLA leave regardless of whether you (and your Dependents, if applicable) were covered under the Plan during your FMLA leave. COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.

VII. Benefits Available Under the Plan

The Plan makes certain health benefits available to Covered Persons. A detailed summary of the specific benefits and scope of coverage is set forth in the Plan's Benefit Description, which is available from the Plan Administrator.

The Plan Sponsor shares the cost of coverage under this Plan with covered Employees. The level of Employee premiums/contributions is set by the Plan Sponsor. The Plan Sponsor reserves the right to change the level of Employee premiums/contributions prior to the commencement of each Plan Year.

VIII. Plan's Right to Recover Benefits – Subrogation & Reimbursement

(A) ***Subrogation.*** The right of subrogation means the right of the Plan to "step into your shoes" and take over your right to receive payments from third parties or to pursue a cause of action against third parties, to the extent of payments made by the Plan. By accepting benefits from the Plan, you are agreeing to the Plan's right of subrogation to any Claim or right of action that you may have against a third party. You may be required to sign an agreement affirming the Plan's right to subrogation before any benefits will be paid to you (or on your behalf) in connection with a particular injury or condition.

> *Example of Subrogation:* You are injured in a car accident and the Plan pays your medical expenses resulting from the accident. You have a Claim against the other driver for your injuries. The Plan may make a Claim against the other driver because either (1) you do not assert a Claim against the driver, or (2) you assert a Claim against the other driver, but it does not include damages for medical expenses that were paid by the Plan.

(B) ***Reimbursement.*** The right of reimbursement is the right of the Plan to recover from you or your covered Dependent any and all benefits previously paid by the Plan with respect to an injury or condition in the event you are compensated for such injury or condition from any source, whether by settlement, judgment, compromise, or otherwise. The right to reimbursement also includes future medical expenses, if any. By accepting benefits under the Plan, you are agreeing to reimburse the Plan out of any recovery you might receive from third parties. If you bring a liability Claim against any third party, benefits payable under this Plan must be included in the Claim. Moreover, the Plan has a right to reimbursement from you, your Covered Dependent(s), and/or any assignee(s) for any benefit overpayments attributable to mistake, clerical error, fraud, or any other reason contributing to a payment not fully payable under the terms of the Plan.

You must not do anything which would prejudice the Plan's rights of reimbursement. You may be required to sign and deliver documents reasonably necessary to secure the rights of the Plan to reimbursement.

> *Example of Reimbursement:* You are injured in a car accident and the Plan pays your medical expenses resulting from the accident. You bring a Claim against the other driver for your injuries, which you eventually settle against the other driver. The Plan is entitled to immediate reimbursement from what you recovered in your settlement for *all benefits* paid by the Plan in connection with your injuries. *You may not reduce the amount owed the Plan in order to account for attorney fees and costs*. Further, the Plan must be paid *first* out of the *total* amount of the settlement.

(C) ***Amount Due.*** The amount owed to the Plan may not be reduced by the attorney fees and costs incurred in asserting your Claim against third parties. Moreover, the Plan's rights of subrogation and reimbursement take precedence over your right to be made whole.

(D) ***Condition of Payment.*** At the Plan's request, you (or your covered Dependent) must take any action, give information, and/or execute instruments required by the Plan, in its discretion, in order to aid the Plan in its enforcement of its rights of recovery through reimbursement and subrogation. If you (or your covered Dependent) fail to comply with such requests, the Plan may withhold benefits, services, payments, or credits due under the Plan.

(E) **Notice of Potential Third-Party Liability.** If a third party may be liable for an injury or illness for which the Plan has paid benefits, you must provide notice to the Plan of such third party's potential liability before commencing a legal action against that third party. If a settlement is reached with that third party (or its insurer) without the formal filing of a legal action, you must provide notice of such settlement to the Plan before the settlement is finalized.

(F) ***Coordination of Benefits.*** If you (or your Covered Dependent) seek benefits under this Plan that are also payable under another medical plan or medical reimbursement arrangement (such as Medicare), the plans will coordinate how benefits are to be paid. The procedures governing this coordination of benefits are set forth in the Core Document.

(G) **Proceeds from Judgment/Settlement Are Plan Assets.** Any amount that you (or your covered Dependent) recover from a third party in connection with a judgment, settlement, or otherwise that arises out of an injury for which the Plan has paid benefits will be considered plan assets, thereby rendering you (or your covered Dependent) a fiduciary with respect to those plan assets. The Plan, in turn, may fully enforce its rights against you (or your covered Dependent) under applicable federal and/or state law.

IX. Claims Procedures

If you have a Claim for benefits under the Plan, you must follow the procedures outlined in Appendix A of this SPD. The Claims Administrator of the Plan is Benefit Management. Please note that Benefit Management has been delegated full discretionary authority in connection with the Plan's internal claims appeal process to make all determinations regarding the administration and payment of Claims, in accordance with the terms of the Plan.

X. Language Assistance

This SPD contains a summary in English of your rights and benefits under the Plan. If you have difficulty understanding any part of this SPD, please contact the Plan Sponsor/Plan Administrator at the address or telephone listed in Section I(A) for assistance.

XI. Amendment or Termination of the Plan

The Plan Sponsor may amend or terminate the Plan at any time by written instrument. Any change to the Plan will be added to the Plan document in writing and communicated to the participants.

APPENDIX A – CLAIMS PROCEDURES

In filing a Claims Appeal under the Plan, you must follow the procedures that are applicable to the specific type of Claim you are appealing. There are five different types of Claims, each of which is defined in a separate part of this Appendix. The various claims are: Urgent Care Claims (Part II); Pre-Service Claims (Part III); Concurrent Care Decisions (Part IV); Post-Service Claims (Part V); and Rescissions of Coverage (Part VI).

PART I – GENERAL PROCEDURES FOR FILING ANY TYPE OF CLAIMS APPEAL

Section A.01 Where to File Claims Appeal. A Claims Appeals must be filed in writing (with the exception of certain Urgent Care claims appeals, as described in Section A.08 below) with the Claims Administrator. Written Claims Appeals shall be sent to the Claims Administrator at the address below:

Benefit Management, LLC
Attn: Claim Appeal Review
P.O. Box 1090
Great Bend, KS 67530-1090

Section A.02 Persons Who May File Claims Appeals. Claims appeals may be filed by the Claimant or by the Claimant's duly authorized representative.

(a) Prior to recognizing any such appointment of an authorized representative, the Claims Administrator may require proof that the representative has been duly appointed.

(b) Notwithstanding the foregoing rule, a health care professional with knowledge of the Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant with respect to an Urgent Care Claims Appeal.

(c) For purposes of these claims procedures, the deadlines applicable to a Claimant shall apply to his/her authorized representative in the event he/she elects to use an authorized representative in filing any Claims Appeal.

Section A.03 Important Definitions in Claims Procedures. The following definitions apply to the claims procedures set forth in this Article of the Plan:

(a) ***Adverse Benefit Determination***. If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively on the basis of fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

(b) ***Appeal***. A Claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." An Appeal will be recognized as valid only if it is submitted by a Claimant or his/her authorized representative in accordance with the Plan's procedures for filing an Appeal of an Adverse Benefit Determination.

(c) ***External Review***. After receiving a Final Adverse Benefit Determination under the Plan's internal Appeal procedure, a Claimant has the right to request an External Review of his/her Claim pursuant to the Plan's External Review procedures, which are set forth in Part VII of this Appendix.

(d) ***Final Adverse Benefit Determination***. If a Claim is denied at the end of the internal Appeal process, the Plan's final decision is known as a "Final Adverse Benefit Determination."

(e) ***Receipt/Received***. The Plan Administrator (or its designee) will be deemed to be in "Receipt" of (or to have "Received") a Claimant's Claim, Appeal, or other information submission only after the Claim, Appeal, or other information submission is received – through electronic means or otherwise – in the physical offices of the Plan Administrator (or its designee). A Claimant will be deemed to be in Receipt of a request for additional information or other notification from the Plan upon *the earlier of* (i) the date that the request/notification is communicated to him/her electronically, or (ii) five (5) days after the request/notification is mailed to his/her mailing address.

Section A.04 Mandatory Exhaustion of Administrative Remedies. Prior to initiating legal action concerning a Claim in any court, state or Federal, against this Plan, any trust used in conjunction with this Plan, the Employer, the Claims Administrator, and/or the Plan Administrator, a Claimant must first exhaust the internal administrative remedies provided in this Article. Failure to exhaust the internal administrative remedies provided in this Article shall be a bar to any civil action concerning a Claim for benefits under this Plan.

Section A.05 Litigation Following Exhaustion of Administrative Remedies. Once a Claimant has exhausted his/her administrative remedies as set forth in this Article, he/she may file a lawsuit challenging the denial of the Claim. *Such lawsuit must be commenced, however, no later than 180 days after the Plan issues a Final Adverse Benefit Determination or, if External Review is sought by the Claimant, no later than 180 days after the Claim is denied in whole or in part on External Review.*

Sections A.06 Compliance with Federal Regulations Governing Claims Procedures. The claims procedures in this Article VI are intended to comply with all applicable federal regulations governing claims procedures for group health plans. The provisions in this Article shall be interpreted, therefore, to comply with all applicable federal regulations and guidance.

PART II – URGENT CARE CLAIMS APPEALS

Section A.07 Definition of Urgent Care Claim. An Urgent Care Claim is a Claim for medical care or treatment in which:

(a) The Plan conditions the receipt of benefits, in whole or in part, on advance approval of the particular care or treatment; and

(b) Using the timetable for deciding non-Urgent Care determinations (e.g., Pre-Service Claims and Post-Service Claims) (*see* Sections A.22 and A.36 below):

(1) Could, in the judgment of a prudent layperson with average knowledge of health and medicine, seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or

(2) Would, in the opinion of a Physician with knowledge of the Claimant's medical condition, subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

Section A.08 **How to File an Urgent Care Claim.** An Urgent Care Claim must include the following information:

(a) The medical care or treatment for which approval is being sought;

(b) The name of the person, organization, or entity to which the expense is to be paid;

(c) The name of the Claimant for whom the approval is being sought and, if such person is not the Employee (or covered class member) requesting the benefit, the relationship of such Claimant to the Employee (or covered class member);

(d) An explanation of why the medical care or treatment in question should be considered to be urgent;

(e) The amount expected to be recovered under any insurance arrangement or other plan with respect to the expense;

(f) A statement that the expense (or portion thereof for which reimbursement is sought under this Plan) has not been reimbursed and is not reimbursable under the Plan; and

(g) Any other information relating to the medical care or treatment in question that the Claimant considers relevant and wishes the Claims Administrator to consider in reviewing the Claim.

An Urgent Care Claim may be filed in writing. If the circumstances make the filing of a written Claim impractical, however, an Urgent Care Claim may also be submitted to the Claims Administrator electronically, over the telephone, or in some other way that is similarly expeditious and that ensures that the Urgent Care Claim is received by the Claims Administrator on a timely basis.

Section A.09 **Time Period for Filing an Urgent Care Claim.** An Urgent Care Claim must be filed with the Claims Administrator as quickly as possible after the Claimant becomes aware of the existence of the Claim.

Section A.10 **Failure to Follow Proper Procedures in Filing an Urgent Care Claim.** If the Claimant fails to follow the proper procedures in filing an Urgent Care Claim, the Claims Administrator shall notify the Claimant as quickly as possible. In no event, however, will the notification be made more than 24 hours after the time the failure took place.

Section A.11 **Failure to Submit Necessary Information.** If the Claimant fails to submit information that is necessary to process an Urgent Care Claim, the Claims Administrator shall notify the Claimant of such failure no more than 24 hours after Receipt of the Urgent Care Claim and shall identify the specific information that is necessary to complete the Urgent Care Claim.

(a) Upon Receipt of such notification, the Claimant shall have 48 hours to provide the requested information to the Claims Administrator.

(b) During the period between the date the additional information is requested and the date it is received by the Claims Administrator, the deadline for deciding the Urgent Care Claim, as set forth in Section A.12, shall be suspended.

(c) Following Receipt of the additional information that was requested by the Claims Administrator, the Claims Administrator shall decide the Urgent Care Claim as soon as possible, but no later than 48 hours after Receipt of the additional information.

Section A.12 Deadline for Deciding an Urgent Care Claim. Following the submission of an Urgent Care Claim that has been filed in accordance with the provisions of this Article, the Claims Administrator shall decide the Urgent Care Claim as quickly as possible, but no later than 72 hours after the Urgent Care Claim was received.

Section A.13 Notification Regarding Initial Benefit Determination on an Urgent Care Claim. The Claims Administrator shall notify the Claimant of the decision that has been made on the Urgent Care Claim. If the Urgent Claim was denied in whole or in part – which is considered an Adverse Benefit Determination – the notice provided to the Claimant shall be provided in a manner that is calculated to be understood by the Claimant. This notification may be provided orally if a written notification is provided within three (3) days after the oral notification.

Section A.14 Deadline for Filing Appeal of an Urgent Care Claim. Although a Claimant is encouraged to file any Appeal of an Adverse Benefit Determination on an Urgent Care Claim as soon as possible, the Claimant shall have up to 180 days following his/her Receipt of the notice of Adverse Benefit Determination to file the Appeal. Any Appeal shall be filed with the Claims Administrator.

Section A.15 Procedures for Appealing Adverse Benefit Determination of Urgent Care Claim. In any Appeal of an Adverse Benefit Determination on an Urgent Care Claim, the following procedures shall be observed:

(a) If requested by the Claimant, the Claims Administrator shall permit the Claimant to submit – where feasible – any information relevant to his/her Appeal either orally or in writing in order to expedite the processing and consideration of the Appeal. All necessary information shall be transmitted between the Claims Administrator and the Claimant by telephone, facsimile, electronic mail, or similar delivery method;

(b) The Claimant shall have the right to present evidence and written testimony as part of the Appeal process;

(c) The evaluation of the Claimant's Appeal shall take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) The Claims Administrator shall designate an appropriate individual or individuals to consider the Appeal. The individual(s) considering the Appeal shall not be the same individual(s) who originally decided the Claim nor shall they be subordinates of the individual(s) who originally decided the Claim;

(e) In considering the Appeal, no deference shall be given to the initial Adverse Benefit Determination;

(f) If the initial Adverse Benefit Determination was based on the Claim being not Medically Necessary or constituting Experimental or Investigational treatment, or some similar exclusion or limit, the individual(s) considering the Appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine

involved in the medical judgment. Any health care professional who is consulted for this purpose shall not have been involved with or consulted regarding the initial Adverse Benefit Determination nor shall such a professional be a subordinate of any professional who was involved with or consulted regarding the initial Adverse Benefit Determination;

(g) If the Claims Administrator has considered, relied upon, or generated any new or additional evidence in denying the Claimant's Appeal, the Claimant must be advised of his/her right to receive, free of charge, a copy of such new or additional evidence and his/her right to respond in writing; and

(h) In connection with the Appeal, the Claims Administrator must identify any medical or vocational experts whose advice was obtained on behalf of the plan in making the initial Adverse Benefit Determination, regardless of whether such advice was relied upon in making the initial Adverse Benefit Determination.

Section A.16 Deadline for Deciding Appeal of Denial of Urgent Care Claim. An Appeal of an Adverse Benefit Determination on an Urgent Care Claim shall be decided within 72 hours following the Claims Administrator's Receipt of the Claimant's request for the Appeal. The Claims Administrator shall notify the Claimant in writing of the decision made on his/her Appeal of an Adverse Benefit Determination of an Urgent Care Claim.

PART III – PRE-SERVICE CLAIMS

Section A.17 Definition of Pre-Service Claim. A Pre-Service Claim is a Claim for which each of the following conditions is satisfied:

(a) The benefit payable by the Plan depends, in whole or in part, upon the pre-approval (or pre-certification) of the underlying medical care or treatment in advance of obtaining the medical care or treatment; and

(b) The Claim is not an Urgent Care Claim (as defined in Section A.07).

Note: A total rescission of Plan coverage as a result of alleged fraud or misrepresentation is not considered a Pre-Service Claim.

Section A.18 How to File a Pre-Service Claim. A Pre-Service Claim shall include the following information:

(a) The amount, date and nature of each expense;

(b) The name of the person, organization or entity to which the expense is to be paid;

(c) The name of the Claimant for whom the approval is being sought and, if such person is not the Employee (or covered class member) requesting the benefit, the relationship of such Claimant to the Employee (or covered class member);

(d) An explanation of why the medical care or treatment in question should be approved;

(e) The amount expected to be recovered under any insurance arrangement or other plan with respect to the expense;

(f) A statement that the expense (or portion thereof for which reimbursement is sought under this Plan) has not been reimbursed and is not reimbursable under the Plan; and

(g) Any other information relating to the medical care or treatment in question that the Claimant considers relevant and wishes the Claims Administrator to consider in reviewing the Claim.

Section A.19 Time Period for Filing a Pre-Service Claim. A Pre-Service Claim must be received by the Claims Administrator sufficiently in advance of the proposed treatment date that the Claims Administrator is able to process the Claim.

Section A.20 Failure to Follow Proper Procedures in Filing a Pre-Service Claim. If the Claimant fails to follow the proper procedures in filing his/her Pre-Service Claim, the Claims Administrator shall notify the Claimant as quickly as possible. In no event, however, will the notification be made more than five (5) days after the time the failure took place. The Claimant shall then have 45 days to resubmit his/her Claim following the proper procedures.

Section A.21 Failure to Submit Necessary Information. If the Claimant fails to submit information that is necessary to process a Pre-Service Claim, the Claims Administrator shall notify the Claimant of such failure no more than 15 days after Receipt of the Claim and shall identify the specific information that is necessary to complete the Claim.

(a) Upon Receipt of such notification, the Claimant shall have 45 days to provide the requested information to the Claims Administrator.

(b) During the period between the date the additional information is requested and the date it is received by the Claims Administrator, the deadline for deciding the Claim, as set forth in Section A.22, shall be suspended.

(c) Following Receipt of the additional information that was requested by the Claims Administrator, the Claims Administrator shall decide the Claim within the number of days that were remaining in the original 15-day period (as extended) as of the date the additional information was requested.

(d) If the requested information is not received by the Claims Administrator within 45 days after the Claimant or the Claimant's authorized representative received the Claims Administrator's request for such information, the Claims Administrator shall deny the Claim.

Section A.22 Deadline for Deciding a Pre-Service Claim. Following the submission of a Pre-Service Claim that has been filed in accordance with the provisions of this Article, the Claims Administrator shall decide the Pre-Service Claim not later than 15 days following the Receipt of the Claim. The Claims Administrator may extend this 15-day period, however, for up to 15 additional days if (a) such an extension is necessary due to matters beyond the control of the Plan, *and* (b) the Claimant is notified of the extension prior to the expiration of the original 15-day period. A situation that is beyond the control of the Plan includes, but is not limited to, a situation in which the Claimant fails to submit information that is necessary to decide a Claim. The Claims Administrator shall notify the Claimant in writing of the decision that was made on the Pre-Service Claim.

Section A.23 Deadline for Filing Appeal of Adverse Benefit Determination on Pre-Service Claim. The Claimant shall have 180 days following the Receipt of a notice of an Adverse Benefit Determination of a Pre-Service Claim to file an Appeal. Any Appeal shall be filed with the Claims Administrator in writing.

Section A.24 Procedures for Appealing Adverse Benefit Determination of Pre-Service Claim. In any Appeal of an Adverse Benefit Determination on a Pre-Service Claim, the following procedures shall be observed:

(a) The Claimant shall have the right to present evidence and written testimony as part of the Appeal process;

(b) The evaluation of the Claimant's Appeal shall take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was submitted or considered in the initial benefit determination;

(c) The Claims Administrator shall designate an appropriate individual or individuals to consider the Appeal. The individual(s) considering the Appeal shall not be the same individual(s) who originally decided the Claim nor shall they be subordinates of the individual(s) who originally decided the Claim;

(d) In considering the Appeal, no deference shall be given to the initial Adverse Benefit Determination;

(e) If the initial Adverse Benefit Determination was based on the Claim being not Medically Necessary or constituting Experimental or Investigational treatment, or some similar exclusion or limit, the individual(s) considering the Appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional who is consulted for this purpose shall not have been involved with or consulted regarding the initial Adverse Benefit Determination nor shall such a professional be a subordinate of any professional who was involved with or consulted regarding the initial Adverse Benefit Determination;

(f) If the Claims Administrator has considered, relied upon, or generated any new or additional evidence in denying the Claimant's Appeal, the Claimant must be advised of his/her right to receive, free of charge, a copy of such new or additional evidence and his/her right to respond in writing; and

(g) In connection with the Appeal, the Claims Administrator must identify any medical or vocational experts whose advice was obtained on behalf of the plan in making the initial Adverse Benefit Determination, regardless of whether such advice was relied upon in making the initial Adverse Benefit Determination.

Section A.25 Deadline for Deciding Appeal of Denial of Pre-Service Claim. An Appeal of an Adverse Benefit Determination on a Pre-Service Claim shall be decided within 30 days following the Claims Administrator's Receipt of the Claimant's request for the Appeal. The Claims Administrator shall notify the Claimant in writing of the decision made on his/her Appeal of the Adverse Benefit Determination of the Pre-Service Claim.

PART IV – CONCURRENT CARE DECISIONS

Section A.26 Definition of Concurrent Care Decision. A Concurrent Care Decision is a decision by the Plan to reduce, terminate, or refuse to extend an ongoing course of treatment (for which pre-approval is required and was previously granted) which is to be provided over a specified period of time or for a specified number of treatments. All Concurrent Care Decisions constitute Adverse Benefit Determinations.

Section A.27 Notification Regarding Concurrent Care Decisions by Plan Involving Reduction or Termination of Covered Treatment. Any reduction or termination by the Plan of an approved, ongoing course of treatment before the end of the approved period of time or number of treatments is an Adverse Benefit Determination. Notification of such a Concurrent Decision shall be given to a Covered Person sufficiently in advance of the reduction or termination of the course of treatment to allow him/her to Appeal and to obtain a determination on review of that Adverse Benefit Determination before it takes effect.

Section A.28 Requested Extension of Course of Treatment. The following rules apply if a Claimant requests an extension of a course of treatment (for which pre-approval is required and was previously granted) beyond the period of time or number of treatments that have been previously approved:

(a) If the course of treatment involves Urgent Care (as defined in Section A.07), the request shall be decided as soon as possible, taking into account the medical exigencies. If the request was received at least 24 hours prior to the expiration of the approved course of treatment, the Claims Administrator shall notify the Claimant of its decision on the Claim no more than 24 hours after Receipt of the request. If the request was not Received at least 24 hours prior to the expiration of the approved course of treatment, the Claims Administrator shall notify the Claimant of its decision on the Claim no more than 72 hours after Receipt of the request.

(b) If the course of treatment does not involve Urgent Care, the request will be treated as a Pre-Service Claim and shall be decided within the time frame applicable to Pre-Service Claims (as set forth in Section A.25).

Section A.29 Deadline for Filing an Appeal of a Concurrent Care Decision. Although a Claimant is strongly encouraged to file any Appeal of an Adverse Benefit Determination on a Concurrent Care Decision as soon as possible, the Claimant shall have up to 180 days following his/her Receipt of the Adverse Benefit Determination to file the Appeal. Any Appeal shall be filed with the Claims Administrator.

Section A.30 Procedures for Appealing Adverse Benefit Determination of Concurrent Care Decision. In any Appeal of an Adverse Benefit Determination involving a Concurrent Care Decision, the following procedures shall be observed:

(a) If requested by the Claimant, the Claims Administrator may permit the Claimant to submit – where feasible – any information relevant to his/her Appeal either orally or in writing in order to expedite the processing and consideration of the Appeal. Where such expedited processing is necessary and appropriate, any information relevant to the Appeal may be transmitted between the Claims Administrator and the Claimant by telephone, facsimile, electronic mail, or similar delivery method;

(b) The Claimant shall have the right to present evidence and written testimony as part of the Appeal process;

(c) The evaluation of the Claimant's Appeal shall take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) The Claims Administrator shall designate an appropriate individual or individuals to consider the Appeal. The individual(s) considering the Appeal shall not be the same individual(s) who originally decided the Claim nor shall they be subordinates of the individual(s) who originally decided the Claim;

(e) In considering the Appeal, no deference shall be given to the initial Adverse Benefit Determination;

(f) If the initial Adverse Benefit Determination was based on the Claim being not Medically Necessary or constituting Experimental or Investigational treatment, or some similar exclusion or limit, the individual(s) considering the Appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional who is consulted for this purpose shall not have been involved with or consulted regarding the initial Adverse Benefit Determination nor shall such a professional be a subordinate of any professional who was involved with or consulted regarding the initial Adverse Benefit Determination;

(g) If the Claims Administrator has considered, relied upon, or generated any new or additional evidence in denying the Claimant's Appeal, the Claimant must be advised of his/her right to receive, free of charge, a copy of such new or additional evidence and his/her right to respond in writing; and

(h) In connection with the Appeal, the Claims Administrator must identify any medical or vocational experts whose advice was obtained on behalf of the plan in making the initial Adverse Benefit Determination, regardless of whether such advice was relied upon in making the initial Adverse Benefit Determination.

Section A.31 Deadline for Deciding Appeal of Concurrent Care Decision. An Appeal of a Concurrent Care Decision (which is, by definition, an Adverse Benefit Determination) shall be decided, as applicable, within the time frame governing either Urgent Care Claims (as set forth in Section A.16) or Pre-Service Claims (as set forth in Section A.25). The Claims Administrator shall notify the Claimant in writing of the decision made on his/her Appeal of a Concurrent Care Decision.

PART V – POST-SERVICE CLAIMS

Section A.32 Definition of Post-Service Claim. A Post-Service Claim is a Claim that is submitted after the underlying medical care or treatment has already been provided. Please note that a Pre-Service Claim (as defined in Section A.17) that was approved in accordance with the provisions applicable to Pre-Service Claims or an Urgent Care Claim (as defined in Section A.07) that was approved in accordance with the procedures applicable to Urgent Care Claims will be treated as a Post-Service Claim once the underlying medical care or treatment has been provided and will, at that point, be subject to the provisions of the Plan that apply to Post-Service Claims. The Claims Administrator will not deny

coverage for any medical care or treatment that had previously been approved under the procedures applicable to Pre-Service Claims or Urgent Care Claims.

Section A.33 **How to File a Post-Service Claim.** Claims must include the following information:

(a) The name and address of the Claimant for whom the expense was incurred and, if such person is not the Employee (or covered class member) requesting the benefit, the relationship of such Claimant to the Employee (or covered class member);

(b) The name and address of the Employee (or covered class member);

(c) The Plan's group number;

(d) The identity of the Employee's (or covered class member's) Employer;

(e) The name, address, telephone number, and tax ID number of the service provider to whom the payment is to be made;

(f) The amount, date, and nature of each expense, along with any corresponding diagnosis and service codes;

(g) A statement that the expense (or portion thereof for which reimbursement is sought under the Plan) may be reimbursable under some other plan coverage; and

(h) Any other information relating to the medical care or treatment in question that is relevant and that should be considered in evaluating the Claim.

Section A.34 **Time Period for Filing Post-Service Claims.** Claims must be filed within 365 days after the charge for the particular medical care or treatment was incurred by the Covered Person. A Claim that is not filed within this time period will be denied or reduced. (Please note that this time period is the deadline to file the initial Claim. This initial submission is typically handled by the medical service provider. The deadline for filing an appeal of a post-service is set forth in Section A.38 below.)

Section A.35 **Failure to Submit Necessary Information.** If the Claimant fails to submit information that is necessary to process a Post-Service Claim, the Claims Administrator shall notify the Claimant of such failure within 30 days following the Receipt of the Claim and shall identify the specific information that is necessary to complete the Claim.

(a) Upon Receipt of such notification, the Claimant shall have 45 days to provide the requested information to the Claims Administrator.

(b) During the period between the date the additional information is requested and the date it is received by the Claims Administrator, the deadline for deciding the Claim, as set forth in Section A., shall be suspended.

(c) Following Receipt of the additional information that was requested by the Claims Administrator, the Claims Administrator shall decide the Claim within the number of days that were remaining in the original 30-day period (as extended) as of the date the additional information was requested.

(d) If the requested information is not received by the Claims Administrator within 45 days after the Claimant Received the Claims Administrator's request for such information, the Claims Administrator shall deny the Claim.

Section A.36 Deadline for Deciding a Post-Service Claim. Following the submission of a Post-Service Claim that has been filed in accordance with the provisions of this Article, the Claims Administrator shall decide the Post-Service Claim not later than 30 days following the Receipt of the Claim. The Claims Administrator may extend this 30-day period, however, for up to 15 additional days if (a) such an extension is necessary due to matters beyond the control of the Plan, *and* (b) the Claimant is notified of the extension prior to the expiration of the original 30-day period. A situation that is beyond the control of the Plan includes, but is not limited to, a situation in which the Claimant fails to submit information that is necessary to decide a Claim.

Section A.37 Notification Regarding Initial Adverse Benefit Determination on Post-Service Claim. The Claims Administrator shall notify the Claimant in writing of the decision that was made on the Post-Service Claim. If the Claim was denied in whole or in part – which is considered an Adverse Benefit Determination – the notice provided to the Claimant shall be written in a manner calculated to be understood by the Claimant.

Section A.38 Deadline for Filing Appeal of Adverse Benefit Determination on Post-Service Claim. The Claimant shall have 180 days following the Receipt of a notice of an Adverse Benefit Determination of a Post-Service Claim to file an Appeal. Any Appeal shall be filed with the Claims Administrator in writing.

Section A.39 Procedures for Appealing Adverse Benefit Determination of Post-Service Claim. In any Appeal of an Adverse Benefit Determination on a Post-Service Claim, the following procedures shall be observed:

(a) The Claimant shall have the right to present evidence and written testimony as part of the Appeal process;

(b) The evaluation of the Claimant's Appeal shall take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was submitted or considered in the initial benefit determination;

(c) The Claims Administrator shall designate an appropriate individual or individuals to consider the Appeal. The individual(s) considering the Appeal shall not be the same individual(s) who originally decided the Claim nor shall they be subordinates of the individual(s) who originally decided the Claim;

(d) In considering the Appeal, no deference shall be given to the initial Adverse Benefit Determination;

(e) If the initial Adverse Benefit Determination was based on the Claim being not Medically Necessary or constituting Experimental or Investigational treatment, or some similar exclusion or limit, the individual(s) considering the Appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional who is consulted for this purpose shall not have been involved with or consulted regarding the initial Adverse

Benefit Determination nor shall such a professional be a subordinate of any professional who was involved with or consulted regarding the initial Adverse Benefit Determination;

(f) If the Claims Administrator has considered, relied upon, or generated any new or additional evidence in denying the Claimant's Appeal, the Claimant must be advised of his/her right to receive, free of charge, a copy of such new or additional evidence and his/her right to respond in writing; and

(g) In connection with the Appeal, the Claims Administrator must identify any medical or vocational experts whose advice was obtained on behalf of the plan in making the initial Adverse Benefit Determination, regardless of whether such advice was relied upon in making the initial Adverse Benefit Determination.

Section A.40 Deadline for Deciding Appeal of Denial of Post-Service Claim. An Appeal of an Adverse Benefit Determination on a Post-Service Claim shall be decided within 60 days following the Claims Administrator's Receipt of the Claimant's request for the Appeal. The Claims Administrator shall notify the Claimant of the decision made on his/her Appeal of the Adverse Benefit Determination of the Post-Service Claim.

PART VI – RESCISSION OF COVERAGE

Section A.41 Definition of Rescission of Coverage. A "Rescission of Coverage" refers to the Plan's total rescission of a Claimant's coverage under the Plan on the basis of fraud or misrepresentation.

Section A.42 Notice of Rescission. In the case of a Rescission of Coverage, the Plan must provide notice to a Covered Person of the rescission of his/her coverage at least 30 days prior to the effective date of the rescission. This notice serves as an Adverse Benefit Determination.

Section A.43 Deadline for Filing an Appeal. The Claimant shall have 180 days following the Receipt of a notice of a Rescission of Coverage to file an Appeal. Any Appeal shall be filed with the Claims Administrator in writing.

Section A.44 Required Procedures In Connection with Filing and Deciding Appeal of Rescission of Coverage. The procedures for a Claimant to Appeal a Rescission of Coverage, and the Claims Administrator's deadline for deciding such an Appeal, shall be the same as those that govern Post-Service Claims, as set forth in Sections A.39-A.40.

PART VII – EXTERNAL REVIEW PROCESS

If a Claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, the Claimant may (but does not have to) request that the Claim be reviewed under the Plan's External Review process. As described in detail below, the External Review process entails a review of the Claim by an independent third-party organization.

Section A.45 Deadline for Requesting External Review of Final Adverse Benefit Determination. A request for External Review of a Final Adverse Benefit Determination must be filed by the Claimant or his/her authorized representative in writing within four (4) months after Receipt of the Final Adverse Benefit Determination.

Section A.46 Determination Whether Claim is Eligible for External Review. Within five (5) days after receiving a Claimant's request for External Review, the Plan Administrator shall determine whether the Claim is eligible for review under the External Review process. This determination is based on whether:

(a) The Claimant is/was covered under the Plan at the time the Claim was made or incurred;

(b) The denial relates to the Claimant's failure to meet the Plan's eligibility requirements. (If the Claim involves an eligibility issue, External Review is not available);

(c) The Claimant has exhausted the Plan's internal Claims and Appeal procedures; and

(d) The Claimant has provided all the information required to process an External Review.

Within one (1) business day after completion of this preliminary review, the Claims Administrator will provide written notification to the Claimant of whether the Claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Claims Administrator will notify the Claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the Claims Administrator's notice will describe the information needed to complete it. The Claimant will have 48 hours or until the last day of the 4-month filing period, whichever is later, to submit the additional information.

Section A.47 Assignment to Independent Review Organization for External Review. If the Claimant's request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the Claimant, in writing, that the request for External Review has been accepted. The notice will include a statement that the Claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

Section A.48 Evaluation of Claim by IRO. If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(a) The Claimant's medical records;

(b) The attending health care professional's recommendation;

(c) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, Claimant, or the Claimant's treating provider;

(d) The terms of the Plan;

(e) Appropriate practice guidelines;

(f) Any applicable clinical review criteria developed and used by the Plan; and

(g) The opinion of the IRO's clinical reviewer.

Section A.49 Claim Decision by IRO. The IRO must provide written notice to the Plan and the Claimant of its final decision within 45 days after the IRO receives the request for the External Review.

Section A.50 Availability of Expedited External Review. Generally, a Claimant must exhaust the Plan's Claims and Appeal procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review. Expedited External Review is available if either of the following two conditions is satisfied:

(a) *Requiring Appeal of Adverse Benefit Determination Under Plan's Internal Claims and Appeal Procedure Timetable Would Seriously Jeopardize Claimant's Life or Health*. The Claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal procedures would seriously jeopardize the Claimant's life or health or ability to regain maximum function and the Claimant has filed a request for an expedited internal review; or

(b) *Final Adverse Benefit Determination Involves Emergency Services and Claimant Remains Hospitalized.* The Claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the Claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO.

The IRO must then make its determination and provide a notice of the decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours.

PREVENTIVE HEALTH SERVICES

BENEFIT DESCRIPTION

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

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

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Claims Administrator.

PART I - SCHEDULE OF BENEFITS

VERIFICATION OF ELIGIBILITY

Verification of Eligibility (800) 290-1368

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

PREVENTIVE HEALTH BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including - but not limited to - the Plan Administrator's determination that: care and treatment is Medically Necessary; charges are the Allowed Amount; services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

POST-SERVICE CLAIM REVIEW

The Plan reserves the right to conduct claim review to ensure that appropriate billing and coding guidelines are applied to Covered Charges. This includes - but is not limited to - guidelines as stipulated by the Centers for Medicare and Medicaid, the American Medical Association, and the Federal Register. Code edits including - but not limited to - reductions and/or denials based on the aforementioned guidelines may be applied.

PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers in the **First Health Network,** called Network Providers, who have agreed to certain reduced fees. A list of providers in the Plan's PPO Network is available free-of-charge by contacting the PPO at (800) 226-5116 or visiting www.myfirsthealth.com. Providers are subject to change without notification.

In order for a claim to be appropriately filed, it is important the provider of service has an up-to-date identification card. It is the patient's responsibility to confirm an up-to-date card is on file with the provider.

AFFORDABLE CARE ACT ("ACA")

The Patient Protection and Affordable Care Act, or Affordable Care Act as it is better known, requires qualified plans to cover certain preventive health services and eliminate cost-sharing. The specific Network preventive covered services are listed in the Schedule of Benefits. Defined preventive health services do not include healthcare related services that are provided as a result of Illness, Injury or congenital abnormality.

This is an understanding of the general preventive health services required as of the issuance of this Plan. Additional guidance by Health and Human Services, Internal Revenue Service and the Centers for Medicare and Medicaid Services and/or changes in the current understanding of preventive health services may require modifications to benefits of the Plan and/or premiums.

PERCENTAGE PAYABLE BY THE PLAN

Eligible preventive health services received through a Network Provider are paid by the Plan at 100% without cost-sharing. *Preventive health services received through a Non-Network provider are not*

covered by the Plan and no payment will be made. In the event there is no Network Provider for the services required, the Plan may consider the Allowed Amount for the Non-Network provider.

SCHEDULE OF BENEFITS

General Preventive Health Services	
Abdominal Aortic Aneurysm Screening	One-time screening limited to ultrasonography in men who have ever smoked ages 65 through 75 years.
Alcohol Misuse Screening and Counseling	Screening for and counseling to reduce alcohol misuse. Brief behavioral counseling interventions available for persons who engage in risky or hazardous drinking. Does NOT include care, treatment, or services for alcohol or substance abuse.
Aspirin Use	Limited to the following ages: • Female: 11 through 78 years • Men: 45 through 78 years *Requires Physician's written order. Available through Prescription Drug Card, see "Part V - Prescription Drug Card Benefits".*
Blood Pressure Screening	Available for all persons as an integral part of an annual exam.
Cholesterol Screening	Available for all persons once per Benefit Year.
Colorectal Cancer screening	Limited to adults ages 50 to 75 years. If family history of colorectal cancer is present, age limitation does not apply. Limited to: • Fecal occult blood testing once per Benefit Year, • Sigmoidoscopy every 5 Benefit Years, or • Colonoscopy every 10 years. *Colorectal cancer screening performed in connection with a diagnosis or treatment of a medical condition is not considered a preventive health service and it is not covered.*
Depression Screening	Available for all persons.
Diabetes (Type 2) Screening	Limited to asymptomatic persons ages 18 and older with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
Healthy Diet Counseling	Counseling for a healthy diet when a person has hyperlipidemia or other known risk factors for cardiovascular and diet related chronic disease. Intensive counseling may be delivered by a Physician or Specialist working within the scope of his or her license such as a licensed nutritionist or dietician.
Falls Prevention	Limited to: • Exercise or physical therapy that is provided by a licensed health care provider, and • Vitamin D supplementation (*requires a Physician's written order)* in community-dwelling adults ages 65 and older who are at increased risk for fall. *Vitamin D supplementation requires Physician's written order. Available through Prescription Drug Card, see "Part V - Prescription Drug Card Benefits".*
Hepatitis B Screening	Available to: • Persons at increased risk • Pregnant women
Hepatitis C Screening	Available for persons with high risk for infection and a one-time screening for persons born between 1945 and 1965.

HIV Screening	Available to: • Persons ages 15 to 65, • Younger adolescents and older adults who are at increased risk, • All pregnant women including those who present in labor who are untested and whose HIV status is unknown.
Immunization Vaccines	Standard vaccinations are covered as recommended by the Center for Disease Control. Vaccinations for overseas travel are excluded.
Lung Cancer Screening	Limited to once per Benefit Year with low-dose computed tomography in adults ages 55 to 80 years
Obesity Screening and Counseling	Intensive, multicomponent behavioral counseling intervention is available for persons with a body mass index of 30/kg/m^2 or higher.
Preventive Exam/Routine Physical	Limited to once per Benefit Year.
Preventive Laboratory Services	Limited to once per Benefit Year.
Prostate Cancer Screening	Limited to once per Benefit Year.
Sexually Transmitted Infection (STI) Counseling	High-intensity behavioral counseling to prevent sexually transmitted infections is available for all sexually active persons.
Skin Cancer Behavioral Counseling	Counseling to minimize exposure to ultraviolet radiation to reduce risk for skin cancer limited to ages 10 to 24 years.
Syphilis Screening	Available for all sexually active persons.
Tobacco Use Screening and Interventions	Tobacco use screening is completed when the clinician obtains the patient's lifestyle history. Tobacco cessation interventions are available for persons who use tobacco products. Interventions are: • Smoking cessation products, such as Chantix, limited to 2 cessation attempts per Benefit Year (requires a Physician's written order), • Education, • Brief counseling to prevent the initiation of tobacco use in school-age children, or • Augmented, pregnancy-tailored counseling for pregnant women who smoke. *Smoking cessation products require Physician's written order. Available through Prescription Drug Card, see "Part V - Prescription Drug Card Benefits".*

Preventive Health Services for Women

See also "General Preventive Health Services" for additional preventive health services covered by this Plan.

Anemia Screening	Available for asymptomatic pregnant women.
Bacteriuria Screening	Screening for asymptomatic bacteriuria with urine culture for pregnant women.
BRCA Risk Assessment and Genetic Counseling/Testing (BRCA 1 and BRCA 2)	Available for women who have family members with breast, ovarian, tubal, or peritoneal cancer. Women with a positive result may receive genetic counseling and, if indicated after counseling, BRCA testing.

Breast Cancer Mammography Screening	Limited to once per Benefit Year. *A mammogram performed in connection with a diagnosis or treatment of a medical condition is not considered a preventive health service and it is not covered.*
Breast Cancer Preventive Medications	Women at increased risk for breast cancer may receive counseling from their Physician about risk-reducing medications. Preventive Care Services includes coverage for the risk-reducing medication in women who are at increased risk for breast cancer and low risk of adverse medication effects, such as tamoxifen or raloxifene.

Breastfeeding Comprehensive Support and Counseling	Coverage is limited to comprehensive lactation (breastfeeding) support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for breastfeeding equipment.
	• Breast pumps for post-partum women are limited as follows:
	  ○ One manual or electric breast pump purchase per delivery is covered.
	  ○ Benefit available after participant is delivered of the baby.
	  ○ Breast pumps come with certain supplies, such as tubing, shields, and bottles. All supplies are excluded (i.e. creams, nursing bras, bottles, replacement tubing for breast pump).
	  ○ Breast pumps must be purchased from a participating DME vendor.
	  ○ Hospital grade breast pumps are excluded and not covered.

Cervical Cancer Screening	Limited to women once per Benefit Year.
Chlamydia Infection Screening	Available for women.
FDA-Approved Contraception Methods, Sterilization Procedures, and Contraceptive Counseling	Available for women as follows: Education and counseling related to contraceptives and sterilization. Surgical sterilization (hysterectomies are excluded). Contraceptive methods (devices and associated procedures, such as device removal, and pharmaceutical contraceptives for women with reproductive capacity). • OTC Contraceptives: female condoms, sponges, spermicides, emergency contraception • Cervical Caps • Diaphragms • Injections • Implantable Rods • IUDs • Oral contraceptives (generic only unless a generic is not available or compelling reason exists for the patient's use of a brand name product) • Trans-dermal contraceptives • Vaginal rings *Many contraceptive products are available through the Prescription Drug Card and require Physician's written order. See "Part V - Prescription Drug Card Benefits".*
Folic Acid Supplementation	Folic Acid supplementation is available for women of child-bearing age. *Requires Physician's written order. Available through Prescription Drug Card, see "Part V - Prescription Drug Card Benefits".*

Gestational Diabetes Screening	Limited to pregnant women who are asymptomatic for diabetes.
Gonorrhea Screening	Available for all sexually active women.
Human Papillomavirus (HPV) DNA Test	Limited to ages 30 years and older once every 3 Benefit Years.
Intimate Partner Violence Screening and Intervention	Available for women of childbearing age who do not have signs or symptoms of abuse including domestic violence. Includes intervention services for women who screen positive.
Osteoporosis screening	Available for women beginning at age 60 or younger if there is an increased risk of fracture.
Rh Incompatibility Screening	Available for women. If screening is positive, Rh incompatibility treatment is a Preventive Care charge.
Sexually Transmitted Infections Counseling	Limited to sexually active women once per Benefit Year.
Syphilis Screening	Available for sexually active women limited to once per Benefit Year.
Well Woman Visit	Annual preventive care visit for women ages 18 and older to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal obstetrical office visits. Several visits may be needed to obtain all necessary recommended preventive services. *Benefits for pregnancy are limited. The only benefits for pregnancy that are covered by this Plan are the specific pregnancy benefits described in this Schedule. Services such as delivery, x-rays, ultrasounds, facility charges, and medications associated with pregnancy are NOT covered. The laboratory services specifically described are the only laboratory services covered by the Plan.*
Preventive Pediatric Health Services (Birth to age 21 years)	
See also "General Preventive Health Services" for additional preventive health services covered by this Plan.	
Physical Examination	Age-appropriate physical examination for preventive pediatric health. Each exam may include a medical history and body measurements: length/height/weight, head circumference, weight for length, body mass index, and blood pressure. Some of the assessments and screenings listed below may also be integral parts of the exam.
Developmental/Behavioral Assessments	
Alcohol and Drug Use Assessments	Available to children to 21 years.
Autism Screening	Available to children to 21 years.
Behavioral/Psychosocial Assessments	Available to children to 21 years
Depression Screening	Available to children to 21 years.
Developmental Screening	Available to children to 21 years.
Developmental Surveillance	Available to children to 21 years.
Procedures	
Newborn Blood Screening	Limited to newborns using the Recommended Uniform Newborn Screening Panel as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children and state newborn screening laws/regulations.
Cervical Dysplasia Screening	Available for sexually active females.

Critical Congenital Heart Defect Screening	Limited to newborns using pulse oximetry.
Hematocrit or Hemoglobin Screening	Available for children to age 21.
Hemoglobinopathies or Sickle Cell Screening	Limited to newborns.
Hypothyroidism Screening	Limited to newborns.
Phenylketonuria (PKU) Screening	Limited to newborns.
Lead Screening	Limited to: Birth up to 21 years of age.
Tuberculin Test	Available for children to age 21.
Other Services	
Chemoprevention of Dental Caries	Limited to: • Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption, and • Oral fluoride supplementation for children ages 6 months through 4 years of age. *Oral fluoride requires Physician's written order. Available through Prescription Drug Card, see "Part V - Prescription Drug Card Benefits".*
Gonorrhea Prophylactic Medication	Limited to newborns.
Hearing Loss Screening	Limited to newborns.
Iron Supplements	Available for children ages 6 months to age 12 months. *Requires Physician's written order. Available through Prescription Drug Card, see "Part V - Prescription Drug Card Benefits".*
Obesity Screening and Counseling	Available for children ages 6 and older. Includes comprehensive, intensive, behavioral counseling intervention to promote improvement in weight status.
Oral Health Risk Assessment	Available for children birth through age 10.
Sensory Screening – Vision	Available for all children. Generally, part of a well-child visit.
Sensory Screening – Hearing (beyond newborn screening)	Available for all children. Generally, part of a well-child visit.
Visual Acuity Screening	Limited to visual acuity screening for children between the ages of 3 and 5 years to detect the presence of amblyopia or its risk factors.
Vision Exam Paid by the Plan at 100% regardless of network or non-network status	Limited to one (1) vision exam including refraction per Benefit Year. Ages birth to 21 years.
Dental Exam Paid by the Plan at 100% regardless of network or non-network status	Limited to one (1) dental exam including cleaning and polishing per Benefit Year. Does not include dental x-rays. Ages birth to 21 years.

PART II – PREVENTIVE HEALTH SERVICES BENEFITS

Preventive Health Benefits apply when Covered Charges are incurred by a Covered Person for preventive health services as shown in the Schedule of Benefits.

BENEFIT PAYMENT

Each Benefit Year, benefits will be paid for the Covered Charges of a Covered Person at the rate shown under "Percentage Payable by the Plan". No benefits will be paid for services in excess of any limit listed in the Schedule of Benefits.

ORDER OF CLAIMS DETERMINATION

Many times claims for covered services are not submitted in the same order the covered services are provided. Regardless of the order claims are incurred, the Plan benefits will be applied to covered services in the sequence that claims are submitted and ready for payment.

COVERED CHARGES

Covered Charges are the Allowed Amounts that are incurred for the items of service and supply shown in the Schedule of Benefits. These charges are subject to the benefit limits, exclusions and other provisions of the Plan. A charge is incurred on the date that the service or supply is performed or furnished.

PART III - DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Affordable Care Act means the "Patient Protection and Affordable Act" enacted on March 23, 2010 and any amendments thereto.

Allowed Amount means the amount that the Plan determines to be the maximum amount payable for a service or supply provided. For services provided by Network Providers, the Allowed Amount is a negotiated amount that the Network Providers have agreed to accept as payment in full for services received by a Covered Person. For services received from providers who are not participating in the network, the Plan will either limit the amount it allows for Covered Charges to the lesser of (i) the provider's billed charge or (ii) an amount equal to 120% of the current Medicare allowable fee for the appropriate area, as such information is made publicly available. The Plan Administrator may, in its discretion, elect to issue an additional payment, in an amount not to exceed 150% of current Medicare allowable fees for the appropriate area, as such information is made publicly available, if doing so is found to be in the best interest of the Covered Person. If there is no corresponding Medicare reimbursement rate for a charge from a non-network provider, the Allowed Amount will be an amount which is Usual and Customary, and Reasonable and Appropriate. The Covered Person is responsible for payment of deductibles, copayment/coinsurance amounts and non-covered services.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Approved Clinical Trial means a phase I, II, III or IV trial which is:

- **(1)** Conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, and
- **(2)** Is one of the following:
  - **(a)** Federally funded**,** or
  - **(b)** Is either:
    - **i** Conducted under an investigational new drug application (IND)reviewed by the Food and Drug Administration, or
    - **ii** A drug trial that is exempt from the IND application requirements.

Assisted Reproductive Technology (ART) means any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pronuclear stage tubal transfer, artificial insemination, intracytoplasmic sperm injection, embryo transport, selective reduction, and cryo-preservation.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Congenital Abnormality is a medical condition that existed at birth and is diagnosed within the first five years of life.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person means an Eligible Individual and his/her Dependents who satisfy the eligibility conditions and has entered the Plan.

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

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational means a drug, device, medical treatment or procedure that meets any of the following protocols:

(1) The drugs or dosages, devices, equipment, services, supplies, tests or medical treatment or procedures (generally, individually or collectively called ("Regimens")) have not received final approval from the U.S. Food and Drug Administration for the lawful marketing of the Regimens for the specific Injury or Illness to be treated.

(2) The Regimens have not received the approval or endorsement of the American Medical Association (AMA) for the specific Injury or Illness to be treated.

(3) The Regimens have not received the approval or endorsement of the National Institutes of Health (NIH) or its affiliated institutes for the specific Injury or Illness to be treated.

(4) The Regimens are to be or are being used or studied in proposed or ongoing clinical research or clinical trials as evidenced by an Informed Consent or treating facility's protocol; or are part of a proposed or ongoing Phase I, II, or III clinical trial; or are the subject of proposed or ongoing research or studies to determine their dosage, safety, toxicity, efficacy, or their efficacy as compared to other means of treatment or diagnosis.

(5) The opinion of medical or scientific experts (as reflected in published reports or articles in medical and scientific literature; or the written protocol(s) used by the treating facility or other facilities studying substantially the same or similar drugs, devices, services, supplies, tests, treatments or other facilities studying substantially the same or similar drugs, devices, services, supplies, tests, treatments or procedures) indicates that further studies, research, or clinical trials of the Regimens are necessary to determine their dosage, safety, toxicity, efficacy, or their efficacy as compared to other means of treatment or diagnosis.

(6) The Regimens have not been proven effective for the specific Injury or Illness as of the date the treatment is provided.

Except,

(7) A drug shall not be considered Experimental and Investigational if all of the following criteria are satisfied:

(a) The drug is approved by the U.S. Food and Drug Administration regardless of the Injury, Illness or diagnosis; and

(b) The drug is appropriate and is generally accepted for the condition being treated by two of the following:

(i) American Hospital Formulary Service Drug Information;

(ii) National Comprehensive Cancer Network's (NCCN) Drugs & Biologics Compendium;

(iii) Thomson Micromedex DrugDex;

(iv) Elsevier Gold Standard Clinical Pharmacology.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

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

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Hospital is a legally operated institution which meets at least one of these tests:

(1) Is accredited as a Hospital under the Hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or

(2) Is a Hospital, as defined, by Medicare, which is qualified to participate and eligible to receive payments in accordance with the provisions of Medicare, or

(3) Is supervised by a staff of Physicians, has twenty-four (24) hour-a-day nursing services, and is primarily engaged in providing either:

(a) General Inpatient medical care and treatment through medical, diagnostic and major surgical facilities on its premises or under its control, or

(b) Specialized Inpatient medical care and treatment through medical and diagnostic facilities (including x-ray and laboratory) on its premises, or under its control, or through a written agreement with a Hospital (which itself qualifies under this definition) or with a specialized provider of these facilities.

(c) A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health, if it meets all of the requirements set forth in clause (a) other than the major surgery requirement.

(d) A free-standing treatment facility, other than a Hospital, whose primary function is the treatment of Alcoholism or Substance Abuse provided the facility is duly licensed by the appropriate governmental authority to provide such service, and is accredited by either

the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Hospital Association.

In no event will the term "Hospital" include a nursing home or an institution or part of one which:

(1) Is primarily a facility for convalescence, nursing, rest, or the aged, or

(2) Furnishes primarily domiciliary or custodial care, including training in daily living routines, or

(3) Is operated primarily as a school.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means. It does not include disease or infection (unless it's pus-producing infection that occurred from an accidental cut or wound); hernia; or injuries caused by biting or chewing.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure, or that which are provided during periods when the medical condition of the patient is not changing, or does not require continued administration by medical personnel.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments, or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medical/Surgical Supplies means items for medical use other than drugs, Prosthetic or Orthotic Appliances, Durable Medical Equipment, or orthopedic footwear which have been ordered by a Physician in the treatment of a specific medical condition and which are usually:

(1) Consumable;

(2) Nonreusable;

(3) Disposable;

(4) For a specific rather than incidental purpose; and

(5) Generally have no salvageable value.

Medically Necessary means care and treatment is recommended or approved by a Physician (or Dentist, with regard to dental care); is consistent with the patient's condition or accepted standards of good medical (and dental practice) care; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical (and dental) services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

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

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Municipal Health Department means a local health department serving a municipality that meets the requirements of State public health laws and regulations.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient is treatment including services, supplies and medicines provided and used at a Hospital, Medical Care Facility, or Birthing Center under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

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

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without a prescription".

Reasonable and Appropriate means an amount of Covered Charges that is identified as eligible for payment by the Plan Administrator in accordance with the terms of the Plan. These amounts may be determined and established by the Plan, at the Plan Administrator's discretion, using normative data such as, but not limited to, the fee(s) which the provider most frequently charges the majority of patients for the service or supply, amounts the provider most often agrees to accept as payment in full either through direct negotiation or through a preferred provider organization network, average wholesale price, and/or manufacturer's retail pricing, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, rates negotiated with the Plan, and/or Medicare reimbursement rates. Medicare rates plus 20% are generally considered to be the Reasonable and Appropriate (and thus maximum payable amount, however, the Plan Administrator may in its discretion, taking into consideration specific circumstances and negotiated terms, deem a greater amount to be payable, up to 150% of Medicare rates. For purposes of defining "Reasonable and Appropriate," the terms(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, person or organizations rendering such treatment, services, or supplies for which a specific charge is made.

Reasonable and Appropriate claims shall be limited to those claims that, in the Plan Administrator's discretion, are services or supplies or fees for services or supplies that are necessary for the care and

treatment of Illness or Injury not unreasonably caused by the treating provider. The determination whether fee(s) or services are Reasonable and Appropriate will be made by the Plan Administrator, taking into consideration such factors as, but not limited to, the findings and assessments of the following entities: (a) national medical associations, societies, and organizations; and (b) the Food and Drug Administration. To be Reasonable and Appropriate, services(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable and Appropriate. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable and Appropriate based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable and Appropriate.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Specialist means a Physician who concentrates on medical activities in a particular specialty of medicine, based on education and qualifications. A Specialist is not a General Medicine Practitioner, Internal Medicine Practitioner, Pediatrician, Family Practice Physician, Obstetrician, Gynecologist, Mental Health or Substance Abuse Practitioner.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Urgent Care Facility means a facility location, distinct from a Hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat Illness or Injury for unscheduled, ambulatory patients seeking immediate medical attention.

Usual and Customary ("U&C") means an amount of Covered Charges that is identified as eligible for payment by the Plan Administrator, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. For purposes of defining "Usual and Customary," the term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred. The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale. The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted), nor does it necessarily refer to the specific service or supply furnished to a Covered Person by a provider of services or supplies, such as a

Physician, therapist, nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary. Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by using normative data such as, but not limited to, Medicare cost-to-charge ratios, average wholesale price for prescriptions. and/or manufacturer's retail pricing for supplies and devices.

Walk-in Retail Health Clinic/Convenience Care means a walk-in health clinic, other than an office, Urgent Care Facility, Pharmacy or independent clinic and not described by any other Place of Service code adopted by the Centers for Medicare and Medicaid Services that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.

PART IV - PLAN EXCLUSIONS

For all benefits shown in the Schedule of Benefits, a charge for the following is not covered:

A. **Abortion.** Expenses incurred for abortion.

B. **Adoptive birth mother.** Expense incurred by an adoptive birth mother.

C. **Alternative medicine,** including - but not limited to - biofeedback, aromatherapy, naturopathy, and homeopathic and holistic treatment or acupuncture/acupressure and hypnosis.

D. **Complications of covered or non-covered treatments.** Care, services, treatment, or supplies required as a result of complications from a covered or non-covered service are excluded by the Plan.

E. **Excess charges.** The part of an expense that is in excess of the Allowed Amount.

F. **Experimental or not Medically Necessary.** Preventive health services that are either Experimental/Investigational or not Medically Necessary.

G. **Government coverage.** Preventive health services furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law. Also, this exclusion does not apply to Covered Charges rendered through the United States Veteran's Administration.

H. **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

I. **Illegal acts.** Charges for services occurring directly or indirectly as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

J. **No charge.** Preventive health services for which there would not have been a charge if no coverage had been in force.

K. **Non-compliance.** All charges in connection with preventive health services where the patient is in non-compliance with medical advice.

L. **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

M. **No Physician recommendation.** Preventive health services not recommended and approved by a Physician; or preventive health services, supplies, or medications when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for a person of the same age, gender and health status.

N. **Not specified as covered.** Charges not specified in the Schedule of Benefits as preventive health services or as preventive care pursuant to the Patient Protection and Affordable Care Act. This includes non-traditional medical services, treatments and supplies which are not specified as covered under this Plan. Non-traditional services include, but are not limited to, missed appointments, completion of claim forms, professional charges for travel expenses, mileage, traveling time, telephone calls, or for services provided over the telephone. Excluded also are Physician's fees for any service, which is not rendered by or in the physical presence of a Physician.

O. **Personal comfort items.** Personal comfort items or other equipment including - but not limited to - air conditioners, air-purification units, humidifiers, dehumidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, hot tubs, pools, hypo-allergenic pillows, power assist chairs, railings, ramps, waterbeds, non-prescription drugs and medicines, first-aid supplies, and non-hospital adjustable beds regardless of a Physician's written order, recommendation or reason the item is to be used.

P. **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

Q. **Relative giving services.** Professional services performed by a person who is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

R. **Services before or after coverage.** Preventive health services for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

S. **Training.** Charges for orthoptics, vision training, vision therapy or subnormal vision aids.

T. **Travel or accommodations.** Charges for travel or accommodations whether or not recommended by a Physician.

PART V - PRESCRIPTION DRUG CARD BENEFITS

Pharmacy Drug Charge

Participating Pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered drugs and supplies through a Pharmacy Benefit Manager. Contact MedTrak Pharmacy Services at (800) 771-4648 to locate participating Pharmacies and to find out more about a specific drug or supply. This information may also be available at www.medtrakrx.com.

The Plan does NOT cover drugs or supplies that are purchased from a non-participating Pharmacy.

Drugs and Supplies Covered by the Prescription Drug Card

Under the ACA certain Prescription Drugs, over-the-counter medications and supplies are covered by the Plan without cost-sharing. Below is a list of preventive medications and supplies covered by the Plan's Prescription Drug Card Benefit. Covered medications are subject to change when new guidelines are issued by Health and Human Services, Internal Revenue Service, the Centers for Medicare and Medicaid, and other sources whose guidance these agencies rely upon. *Only the specific preventive Prescription Drugs, over-the-counter medications, and supplies required by the ACA are covered by this Plan.*

(1) Aspirin for men from ages 45 through 78.
(2) Aspirin for women from ages 11 through 78.
(3) Folic acid supplementation for women of childbearing age.
(4) Oral fluoridation supplementation for Children 6 months of age up to 6 years.
(5) Immunizations (limitations may apply)
(6) Iron supplementation for Children 6 months of age up to 13 months of age.
(7) Tobacco deterrents by prescription only (limitations may apply).
(8) Contraception and sterilization agents (limitations may apply).
(9) Vitamin D2 and D3 products and calcium Vitamin D <1,000 IU limited to ages 65 and older.
(10) Bowel Preps from age 50 up to age 76. (Bisacodyl, Mag Citrate, Milk of Magnesia, PEG 3350-Electrolyte.)
(11) Vaccines of the following types: HPV, Influenza, MMR & MMRV, Pneumonia, Shingles, Tdap and Td, and Varicella. Limitations apply by age and may apply by Pharmacy.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

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

(1) **Abortifacient.** A charge for any drug or medication used to cause/induce an abortion.

(2) **Administration.** Any charge for the administration of a covered Prescription Drug. This exclusion does not apply to the Pharmacy charge for the administration of vaccines.

(3) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription and vitamins D & K with prior authorization.

(4) **Biological sera.** Antigens, blood or blood plasma, parenterals and radiologicals.

(5) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(6) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(7) **Drugs and Supplies which are not specified as preventive medications by the ACA.**

(8) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(9) **Erectile Dysfunction drugs.** Drugs used to treat erectile dysfunction.

(10) **Experimental.** Experimental drugs and medicines as defined by the Plan, even though a charge is made to the Covered Person.

(11) **FDA.** Any drug not approved by the Food and Drug Administration.

(12) **Infertility.** A charge for infertility medication.

(13) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(14) **Investigational medications as defined by the Plan.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(15) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(17) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(18) **Other Exclusions.** Such other exclusions selected by the Plan Sponsor and applied by the Pharmacy Benefit Manager pursuant to the implementation documents of the Plan, which may be updated on an annual basis. For information related to specific exclusions, please contact the Pharmacy Benefit Manager.

Prior authorizations is required for any Prescription Drug costing $750 or more per script.