UNIVERSITY OF SCRANTON
HEALTH AND WELFARE BENEFIT PLAN
TRADITIONAL

Summary Plan Description
Effective: January 1, 1998
Restated: January 1, 2023

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ARTICLE I
ESTABLISHMENT OF THE PLAN: ADOPTION OF THE SUMMARY PLAN DESCRIPTION

THIS SUMMARY PLAN DESCRIPTION ("Plan Document"), made by **University of Scranton** (the "Company" or the "Plan Sponsor") as of January 1, 2023, hereby **amends and restates** the University of Scranton Traditional Plan (the "Plan"), which was originally adopted by the Company, effective January 1, 1998. Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

1.01 Effective Date
The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Employees covered by such agreement (the "Effective Date").

1.02 Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

This Plan is maintained by the University of Scranton. The plan is in accordance with an agreement, effective September 1, 2015, between the Plan Sponsor and Faculty Affairs Council (FAC) Contract, of said union, designated collectively as the "union." A copy of the agreement between the University of Scranton and the union may be obtained upon written request to the Human Resources and is available for examination at the office of Human Resources.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

University of Scranton

By: Patricia L. Tetreault

Name: Patricia L. Tetreault

Title: VP for Human Resources

Date: 7/6/2023

ARTICLE II
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

2.01 Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor, or are funded solely from the general assets of the Plan Sponsor. The Plan's benefits and administration expenses are paid directly from the Employer's general assets. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by the **University of Scranton** and may be inspected at any time during normal working hours by any Participant.

2.02 General Plan Information

Name of Plan:	**University of Scranton Health and Welfare Benefit Plan—Traditional**
Plan Sponsor:	**University of Scranton** **800 Linden Street** **Scranton, PA 18510-4679** **Phone: (570) 941-7767** **Fax: (570) 941-4636**
Plan Administrator: **(Named Fiduciary)**	**University of Scranton** **800 Linden Street** **Scranton, PA 18510-4679** **Phone: (570) 941-7767** **Fax: (570) 941-4636**
Plan Sponsor ID No. (EIN):24-0795495	
Source of Funding:	**Self-Funded**
Plan Status:	**Non-Grandfathered**
Applicable Law:	**ERISA**
Plan Year:	**January 1 through December 31**
Plan Number:	**501**
Plan Type:	**Medical** **Prescription Drug**

Third-Party Administrator:

Highmark Blue Cross Blue Shield
19 North Main Street
Wilkes-Barre, PA 18711
Phone: 1 (888) 338-2211; 1 (866) 280-0486 (TTY)

Claims Fiduciary: **Highmark Blue Cross Blue Shield**
19 North Main Street
Wilkes-Barre, PA 18711
Phone: 1 (800) 338-2211; 1(866) 280-0486 (TTY)

Participating Employer(s):University of Scranton

Agent for Service of Process:
ELD Consulting Group, Ltd. LLC
Consultant
282 Deer Run Drive
Mountain Top, PA 18707
Phone: (570) 200-5592

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

2.03 Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

2.04 Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

2.05 Mental Health Parity

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

2.06 Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA") and the laws of the State of Pennsylvania. The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

2.07 Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to

make determinations in regard to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participants' rights; and to determine all questions of fact and law arising under the Plan.

ARTICLE III
DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.**

“Accident”
“Accident” shall mean a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

“Accidental Bodily Injury” or “Accidental Injury”
“Accidental Bodily Injury” or “Accidental Injury” shall mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

“Actively At Work” or “Active Employment”
“Actively At Work” or “Active Employment” shall mean performance by the Employee of all the regular duties of his or her occupation at an established business location of the Participating Employer, or at another location to which he or she may be required to travel to perform the duties of his or her employment. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor. In no event will an Employee be considered Actively at Work if he or she has effectively terminated employment.

“ADA”
“ADA” shall mean the American Dental Association.

“Adjunctive Procedures”
“Adjunctive Procedures” shall mean physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, and mobilization performed by an individual holding the appropriate licensure and certification.

“Adverse Benefit Determination”
“Adverse Benefit Determination” shall mean any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant’s eligibility to participate in the Plan.

“Affordable Care Act (ACA)”
“The “Affordable Care Act (ACA)” means the health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is commonly used to refer to the final, amended versions of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.”

“AHA”
“AHA” shall mean the American Hospital Association.

“Alcohol and/or Drug Abuse”

“Alcohol and/or Drug Abuse” shall mean any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. For the purposes of the Plan, "drugs" shall be defined as addictive drugs and drugs of abuse listed as scheduled drugs in "The Controlled Substance, Drug, Device and Cosmetic Act" (35 P.S. §780-101 et seq.).

“Allowable Charge”

“Allowable Charge” – In the case of a Preferred Professional Provider, the Allowable Charge is established by a Provider Agreement or is the billed amount, whichever is less, and will be accepted by the Preferred Professional Provider as payment in full for Covered Services. The Participant will be liable for any Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Services have been exhausted, and charges for non-Covered Services.

In the case of a Non-Preferred Participating Professional Provider, the Allowable Charge is based on the payment/rate that the Host Blue passes on to First Priority Life, or the billed amount, whichever is less. With the exception of Outpatient Emergency Services[1], the Participant will be liable for any Non-Preferred Participating Professional Provider Deductibles or Coinsurance, or Copayments. The Participant will also be responsible for amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Services have been exhausted, and charges for non-Covered Services.

In the case of a Non-Preferred Professional Provider, the Allowable Charge is the same amount First Priority Life would pay to a Preferred Provider, or is the billed amount, whichever is less, with the exception of Outpatient Emergency Services[1]. The Participant is liable for charges that exceed the Allowable Charge, with the exception of Outpatient Emergency Services. The Participant is also liable for any Non-Preferred Professional Provider Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Services have been exhausted, and charges for non-Covered Services.

In the case of a Preferred Facility Provider, the Allowable Charge is established by a Provider Agreement pertaining to payment for Covered Services and will be accepted by the Preferred Facility Provider as payment in full for Covered Services. The Participant is liable for any Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Services have been exhausted, and charges for non-Covered Services.

In the case of a Non-Preferred Participating Facility Provider, the Allowable Charge is the payment/rate that the Host Blue passes on to First Priority Life or the billed amount, whichever is less. With the exception of Outpatient Emergency Services[1], the Participant is liable for any Non-Preferred Participating Facility Provider Deductibles, Coinsurance, or Copayments. The Participant is also responsible for amounts exceeding any Benefit Maximum, amounts exceeding any Lifetime Maximums, charges after Covered Medical Services have been exhausted, and charges for non-Covered Services.

In the case of a Non-Preferred Facility Provider, the Allowable Charge is the same amount First Priority Life would pay for services received by a Preferred Facility Provider, or the billed amount, whichever less, with the exception of Outpatient Emergency Services[1]. The Participant is liable for charges that exceed the Allowable Charge, with the exception of Outpatient Emergency Services. The Participant is also liable for any Non- Preferred Facility Provider Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Services have been exhausted, and charges for non-Covered Services.

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[1] In the event that the Participant received Outpatient Emergency Services by a Non-Preferred Participating/Non-Preferred Provider, Highmark Blue Cross Blue Shield will provide coverage at the Preferred Provider level and the Participant’s Out-Of-Pocket expenses will be no greater than the amount that would have been incurred if a Preferred Provider had been used.

Participants may contact BlueCare Service Representatives toll-free at 1-888-338-2211 weekdays during normal business hours for a determination of Covered Services. Hearing impaired persons can call (TTY) 1-866-280-0486. Participants may also write to:

Highmark Blue Cross Blue Shield
19 North Main Street
Wilkes-Barre, PA 18711"

"Alternate Recipient"
"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

"Alternative Treatment Plan"
"Alternative Treatment Plan" shall mean a voluntary program whereby the Participant is offered cost-effective treatment alternatives in lieu of the stated covered services in the Plan, without compromising the quality of care. The Plan's Care Management Department, in cooperation with the Physician, organizes and coordinates care through multi-disciplinary resources.

"AMA"
"AMA" shall mean the American Medical Association.

"Ambulatory Surgical Facility"
"Ambulatory Surgical Center" shall mean any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

"Applied Behavioral Analysis"
"Applied Behavioral Analysis" shall mean the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

"Approved Clinical Trial"
"Approved Clinical Trial" means a phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new Drug application reviewed by the FDA (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include

1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out-of Network benefits are otherwise provided under the Plan.

"Assignment of Benefits"
"Assignment of Benefits" shall mean an arrangement whereby the Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Participant and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

"Autism Service Provider"
"Autism Service Provider" shall mean a person, entity or group providing treatment of Autism Spectrum Disorders, pursuant to a treatment plan, that is properly licensed or certified.

"Autism Spectrum Disorder (ASD)"
"Autism Spectrum Disorder (ASD)" shall mean any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

"Behavior Specialist"
"Behavior Specialist" shall mean an individual who designs, implements or evaluates a behavior modification intervention component of a Treatment Plan, including those based on Applied Behavioral Analysis, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function, through skill acquisition and the reduction of problematic behavior.

"Behavioral Health Acute Care"
"Behavioral Health Acute Care" shall mean health care delivered to a Participant, experiencing an acute Illness or trauma, consisting of high level skilled psychiatric or Substance Abuse services within a free-standing Psychiatric Hospital, a psychiatric unit of a general Hospital or a Detoxification unit within a Hospital setting.

"Benefit Period"
"Benefit Period" shall mean the length of time during which charges for covered services must be Incurred in order to be eligible for payment (either Calendar Year or a Benefit Year).

"Blue Card"
"Blue Card" shall mean a program, which allows a Participant to access Covered Services from Participating Providers located outside the geographic area serviced by the Plan and which are participating with their local Blue Cross and/or Blue Shield Licensee. The local Blue Cross and/or Blue Shield Licensee, which serves the geographic area where the covered service is provided, is referred to as the on-site Blue Cross and/or Blue Shield Licensee.

"Business Day"
"Business Day" shall mean a day that the Network is open for business.

"Calendar Year"
"Calendar Year" shall mean a one-year period which begins on January 1 and ends on December 31.

"Cardiac Care Unit"
"Cardiac Care Unit" shall mean a separate, clearly designated Service Area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the treatment of patients who require special medical attention because of their critical condition;
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least two beds for the accommodation of critically ill patients; and
5. It provides at least one professional Registered Nurse, who continuously and constantly attends the patient confined in such area on a twenty-four (24) hour a day basis.

"Centers of Excellence"
"Centers of Excellence" shall mean Medical Care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Third-Party Administrator shall determine which Centers of Excellence are to be used.

Any Participant in need of an organ transplant may contact the Third-Party Administrator to initiate the Pre-Certification process resulting in a referral to a Center of Excellence. The Third-Party Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admission taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

"Chemotherapy"
"Chemotherapy" shall mean the treatment of Disease by chemical or biological therapeutic agents.

"Child(ren)"
"Child(ren)" shall mean, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster Child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

"CHIP"
"CHIP" refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to; as such act, provision or section may be amended from time to time.

"CHIPRA"
"CHIPRA" refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

"Chiropractic Manipulative Treatment (CMT)"
"Chiropractic Manipulative Treatment (CMT)" shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

“Claim Determination Period”
“Claim Determination Period” shall mean each Calendar Year.

“Claims Fiduciary”
“Claims Fiduciary” shall mean the entity to which the Plan Sponsor has allocated certain fiduciary responsibility.

“Clean Claim”
A “Clean Claim” is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third-party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Services in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claim forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Third-Party Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Services as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

“COBRA”
“COBRA” shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Coinsurance”
“Coinsurance” shall mean a specific percentage amount of the Allowable Charge, set forth in the Summary of Benefits, for which the Participant is responsible after the deduction of a Deductible or Copayment, if applicable.

“Coinsurance Maximum”
“Coinsurance Maximum” shall mean a specified dollar amount of Coinsurance Incurred by a Participant, as set forth in the Summary of Benefits, for covered services in a Benefit Period. (Refer to the Summary of Benefits for the period selected by the Plan.)

“Copayment (Copay)”
“Copayment (Copay)” shall mean the amount, if any, a Participant must pay directly to Providers in connection with covered services set forth in the Plan and in the Summary of Benefits.

“Cosmetic Surgery”
“Cosmetic Surgery” shall mean any Surgery, service, Drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

“Covered Mental Health Service Providers”
“Covered Mental Health Service Providers” are Physicians and associated visits which are limited and subject to the Summary of Benefits and terms of this document. Psychiatrists (M.D.), Psychologists (Ph.D.) or counselors licensed to provide individual psychotherapy without supervision in the State they are practicing, may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

“Covered Services”
“Covered Services” shall mean all Medically Necessary Provider services and supplies which are administered by the Third-Party Administrator under the terms of this Plan.

“Custodial Care”
“Custodial Care” shall mean care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

“Deductible”
“Deductible” shall mean a specified amount of covered services, as set forth in the Summary of Benefits, expressed in dollars that must be Incurred by a Participant before the Plan will assume any liability for all or part of the remaining Covered Services.

“Dentist”
“Dentist” shall mean an individual holding a D.D.S. or D.M.D. degree, licensed to practice dentistry in the jurisdiction where such services are provided.

“Dependent”
“Dependent” shall mean one or more of the following person(s):

1. An Employee’s lawfully married Spouse;
2. An Employee’s, Employee’s Spouse’s Child who is less than twenty-six (26) years of age; or
3. An Employee’s, Employee’s Spouse’s Child regardless of age, who was continuously covered prior to attaining the limiting age as listed in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as listed in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within thirty (30) days after the date the Child attains the limiting age as described above. The time limit for written proof of incapacity and dependency is 31 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year.

“Dependent” does not include any person who is a member of the armed forces of any Country or who is a resident of a Country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

“Detoxification”
“Detoxification” shall mean the process whereby an alcohol intoxicated or drug-intoxicated or alcohol-dependent or drug-dependent person is assisted, in a facility properly licensed, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other Drugs, alcohol, Drug or other Drug dependency factors or alcohol in combination with Drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

“Diagnosis”

"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

"Diagnostic Assessment of ASD"
"Diagnostic Assessment of ASD" shall mean Medically Necessary assessments, evaluations or tests performed by a licensed Physician, licensed Physician Assistant, licensed Psychologist or Certified Registered Nurse Practitioner to diagnose whether an individual has an Autism Spectrum Disorder.

"Diagnostic Services"
"Diagnostic Services" shall mean the following procedures ordered by a Physician because of specific symptoms and signs to determine a definite condition or Disease. Diagnostic Services are covered to the extent specified in Medical Benefits section and include, but are not limited to:

1. Diagnostic imaging;
2. Diagnostic pathology, consisting of laboratory and pathology tests;
3. Diagnostic medical procedures, consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other diagnostic medical procedures approved by the Plan; and
4. Allergy testing consisting of percutaneous, intracutaneous and patch tests.

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

"Drug"
"Drug" shall mean insulin and prescription legend Drugs. A prescription legend Drug is a Federal legend Drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription") or a State restricted Drug (any medicinal substance which may be dispensed only by prescription, according to State law) and which, in either case, is legally obtained from a licensed Drug dispenser only upon a prescription of a currently licensed Physician.

"Durable Medical Equipment"
"Durable Medical Equipment" shall mean equipment that:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

"Eligible Person"
"Eligible Person" shall mean a person entitled to be a Participant as specified in the Eligibility for Coverage section.

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

"Emergency Medical Condition"

"Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

"Emergency Services"
"Emergency Services" shall mean, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

"Employee"
"Employee" shall mean a person who is a regular full time Employee of the Participating Employer, including full-time temporary employees continuously employed for more than sixty (60) consecutive days and full-time long-term temporary employees designated as such at time of hire, regularly scheduled to work for the Participating Employer in an Employer Employee relationship. Such person must be scheduled to work at least a minimum of 30 hours per week based on job classification in order to be considered "full time."

"Employer"
"Employer" is University of Scranton.

"ERISA"
"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

"Essential Health Benefits"
"Essential Health Benefits" shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; prescription drugs; mental health and Substance Abuse disorder services, including behavioral health treatment; 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 or Investigational"
"Experimental" and/or "Investigational" ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental, except to the extent it would be considered an Approved Clinical Trial as defined.

A Drug, device, or medical treatment or procedure is Experimental:

1. If the Drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the Drug or device is furnished;
2. If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
    a. Maximum tolerated dose;
    b. Toxicity;
    c. Safety;
    d. Efficacy; and
    e. Efficacy as compared with the standard means of treatment or Diagnosis; or
3. If reliable evidence shows that the consensus among experts regarding the Drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
    a. Maximum tolerated dose;
    b. Toxicity;
    c. Safety;
    d. Efficacy; and
    e. Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same Drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same Drug, device, or medical treatment or procedure.

Subject to a medical opinion, if no other FDA approved treatment is feasible and as a result the Participant faces a life-or-death medical condition, the Claims Fiduciary retains discretionary authority to cover the services or treatment.

The Claims Fiduciary retains maximum legal authority and discretion to determine what is Experimental.

“Facility Other Provider”
“Facility Other Provider” shall mean an Institution or entity, other than a Hospital, that is licensed, where required, to render covered services.

“Facility Provider”
“Facility Provider” shall mean a Hospital or Facility Other Provider, licensed where required, to render covered services.

“Family Coverage”
“Family Coverage” shall mean coverage for the Participant and one or more of the Participant's Dependents.

“Family Unit”
“Family Unit” shall mean the Employee, his or her Spouse and Children.

“Final Internal Adverse Benefit Determination”

Final Internal Adverse Benefit Determination shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

"FMLA"
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.

"FMLA Leave"
"FMLA Leave" shall mean a Leave of Absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

"Freestanding Dialysis Facility"
"Freestanding Dialysis Facility" shall mean a Facility Other Provider, which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home-care basis.

"Freestanding Outpatient Facility"
"Freestanding Outpatient Facility" shall mean a Facility Other Provider, which is primarily engaged in providing Outpatient Diagnostic and/or therapeutic services by or under the direction of Physicians.

"GINA"
"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

"Habilitation/Habilitative Services"
"Habilitation/Habilitative Services" shall mean services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

"Health Breach Notification Rule"
"Health Breach Notification Rule" shall mean 16 CFR Part 318.

"HIPAA"
"HIPAA" shall mean the federal Health Insurance Portability and Accountability Act of 1996.

"Homebound"
"Homebound" shall mean a Participant's condition due to an Illness or Injury which restricts his/her ability to leave his/her place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person, or if he/she has a condition which is such that leaving his/her home is medically contraindicated. The condition of these Participants should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort.

"Home Health Care"
"Home Health Care" shall mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided;
2. The treatment plan covering the Home Health Care service is established and approved in writing by the attending Physician; and
3. The Home Health Care is the result of an Illness or Injury.

“Home Health Care Agency”
“Home Health Care Agency” shall mean an agency or organization which provides a program of Home Health Care and which:

1. Is approved as a Home Health Agency under Medicare;
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
3. Meets all of the following requirements:
    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home;
    b. It has a full-time administrator;
    c. It maintains written records of services provided to the patient;
    d. Its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available; and
    e. Its Employees are bonded and it provides malpractice insurance**.**

“Home Infusion Therapy”
“Home Infusion Therapy” shall mean the preparation and administration of parenteral and enteral nutrition and/or intravenous solutions and Drugs, which are provided in the home or infusion center setting.

“Home Infusion Therapy Agency”
“Home Infusion Therapy Agency” shall mean a Facility Other Provider, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations or a similar accrediting agency acceptable to the Plan; is recognized and licensed by the appropriate regulatory agency to provide services within the scope of its license; provides Home Infusion Therapy services in the Participant’s home or an infusion center; and is responsible for supervising the delivery of such services under a plan authorized by the Physician.

“Hospice”
“Hospice” shall mean a Facility Other Provider, which is primarily engaged in providing supportive care to terminally ill individuals.

“Hospice Care”
“Hospice Care” shall mean a health care program which provides an integrated set of services, primarily in the patient’s home, designed to provide supportive care intended to promote comfort to terminally ill patients and their families. Services are coordinated through a Hospice interdisciplinary team and the Participant’s Physician.

“Hospital”
“Hospital” shall mean an Institution that meets all of the following requirements:

1. It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
2. It is under the supervision of a staff of Physicians;
3. It provides twenty-four (24) hour a day nursing service by Registered Nurses;
4. It is duly licensed as a Hospital, except that this requirement will not apply in the case of a State tax supported Institution;
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training type Institution, or an Institution which is supported in whole or in part by a Federal government fund; and
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

“Hospital” shall also have the same meaning, where appropriate in context, set forth in the definition of “Ambulatory Surgical Center.”

“Host Plan”
“Host Plan” shall mean the on-site Blue Cross/ Blue Shield Plan, which services the geographic area outside the Service Area where the covered services are provided.

“Identification Card/Card Carrier”
“Identification Card/Card Carrier” shall mean the currently effective card/card carrier issued to the Participant and Dependents by the Plan.

“Illness”
“Illness” shall have the meaning set forth in the definition of “Disease.”

“Immediate Family”
“Immediate Family” shall mean the Participant's Spouse, Child, stepchild, parent, brother, sister, mother-in-law, father- in-law, sister-in-law, brother-in-law, daughter-in-law or son-in-law.

“Impregnation and Infertility Treatment”
“Impregnation and Infertility Treatment” shall mean any services, supplies or Drugs related to the Diagnosis or treatment of infertility.

“In Vitro Fertilization (IVF)”
“In Vitro Fertilization (IVF)” shall mean eggs and sperm are combined in a laboratory dish where fertilization occurs. Two days after the retrieval, the embryo is transferred into the woman’s uterus.

“Incurred”
A Covered Expense is “Incurred” on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Services are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Services for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

“Individual Education Plan (IEP)”
“Individual Education Plan (IEP)” shall mean a plan for school-based services.

“Infertility”
“Infertility” shall mean the medically documented diminished ability to conceive or induce conception. A couple is considered infertile if pregnancy does not occur over a one-year period of normal coital activity between a male and female partner without contraceptives. The cause of infertility can be a female or female factor, or a combination of both.

“Injury”
“Injury” shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

“Inpatient”

"Inpatient" shall mean a Participant who is treated as a registered bed patient in a Hospital or Facility Other Provider, who is expected to stay overnight and for whom a Room and Board charge is made.

"Inpatient Mental Health Hospital"
"Inpatient Mental Health Hospital" shall mean a short-term acute care Hospital, which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or the American Osteopathic Hospital Association, or a similar accrediting agency acceptable by the Plan and which provides services that are necessary for short-term evaluation, Diagnosis, and treatment (or crisis intervention) of Serious Mental Illness.

"Inpatient Non-Hospital Residential Care"
"Inpatient Non-Hospital Residential Care" shall mean the provision of medical, nursing, counseling, or therapeutic services to patients suffering from Mental or Nervous Disorders and for the treatment of Serious Mental Illness or Alcohol and/or Drug Abuse or dependency in a residential environment, according to individualized treatment plans.

"Inpatient Non-Hospital Residential Facility"
"Inpatient Non-Hospital Residential Facility" shall mean a Facility Other Provider properly licensed to render an Alcohol and/or Drug Abuse treatment program designed to provide Inpatient Non-Hospital Residential Care. (This is not a half-way house or group home.)

"Institution"
"Institution" shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, home health care center, or any other such facility that the Plan approves.

"Intensive Care Unit"
"Intensive Care Unit" shall have the same meaning set forth in the definition of "Cardiac Care Unit."

"Late Enrollee"
"Late Enrollee" shall mean a Participant who enrolls in the Plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the Plan; or
2. Through special enrollment.

"Leave of Absence"
"Leave of Absence" shall mean a Leave of Absence of an Employee that has been approved by his or her Participating Employer, as provided for in the Participating Employer's rules, policies, procedures and practices.

"Licensed Practical Nurse (LPN)"
"Licensed Practical Nurse (LPN)" shall mean a nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.

"Long-Term Residential Care"
"Long-Term Residential Care" shall mean the provision of long-term diagnostic or therapeutic services (i.e., assistance or supervision in managing basic day to day activities and responsibilities) to patients suffering from Alcohol and/or Drug Abuse or dependency. This care is provided in a long-term residential environment known as a Transitional Living Facility, on an individual, group, and/or family basis, with a program duration greater than sixty (60) days. Long-Term Residential Care is not Inpatient Non-Hospital Residential Care.

"Mastectomy"
"Mastectomy" shall mean removal of all or part of the breast for Medically Necessary reasons as determined by a licensed Physician.

"Maximum"
"Maximum" shall mean the greatest covered service amount payable by the Plan. This could be expressed in dollars, number of days, or number of services for a specified period of time.

Benefit Maximum – The greatest covered service amount payable by the Plan for a specific covered service.

Lifetime Benefit Maximum – The greatest covered service amount payable by the Plan in the Participant's lifetime set forth in the Summary of Benefits.

"Maximum Amount" or "Maximum Allowable Charge"
"Maximum Amount" and/or "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

1. The Usual and Customary amount;
2. The Allowable Charge specified under the terms of the Plan;
3. The Reasonable charge specified under the terms of the Plan;
4. The negotiated rate established in a contractual arrangement with a Provider; or
5. The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

"Medical Care/Medical Services"
"Medical Care/Medical Services" shall mean services rendered by a Professional Provider intended to prevent Illness (routine preventive care) and/or restore health (treatment of an Illness or Injury).

"Medical Child Support Order"
"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for Child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical Child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"Medical Care Necessity," "Medically Necessary," or "Medical Necessity"
"Medical Care Necessity," "Medically Necessary," "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than

alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Participant's Sickness or Injury without adversely affecting the Participant's medical condition.

1. It must not be maintenance therapy or maintenance treatment;
2. Its purpose must be to restore health;
3. It must not be primarily custodial in nature;
4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and
5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Charge.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Third-Party Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

"Medical Record Review"
"Medical Record Review" is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Claims Fiduciary or may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

"Medically Necessary Leave of Absence"
"Medically Necessary Leave of Absence" shall mean a Leave of Absence by a full-time student Dependent at a postsecondary educational Institution that:

1. Commences while such Dependent is suffering from a serious Illness or Injury;
2. Is Medically Necessary; and
3. Causes such Dependent to lose student status for purposes of coverage under the terms of the Plan.

"Medicare"
"Medicare" shall mean the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

"Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA"
"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are

covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and
2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

"Mental or Nervous Disorder"
"Mental or Nervous Disorder" shall mean any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

"Metabolic Formulas"
"Metabolic Formulas" shall mean special nutritional formulas administered under the direction of a Physician, which are necessary to sustain life for a genetic metabolic disorder.

"Morbid Obesity"
"Morbid Obesity" shall mean the term that refers to patients who have a body mass index (BMI) of 40 or greater.

"National Medical Support Notice" or "NMSN"
"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the Child or Children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying Child support order.

"Network"
"Network" shall mean the medical Provider Network the Plan contracts to access discounted fees for service for Participants. The Network Provider will be identified on the Participant's identification card.

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

"Non-Occupational Injury"
"Non-Occupational Injury" shall have the meaning set forth in the definition of "Injury."

"Non-Network Fee Schedule (NNFS)"
"Non-Network Fee Schedule (NNFS)" is a fee schedule used to re-price Non-Network claims.

"Nutritional Therapy"
"Nutritional Therapy" shall mean nutritional diagnostic, therapy, and counseling services for the purpose of Disease management which are furnished by a licensed health care professional to help a person make and maintain healthy dietary changes.

"Open Enrollment Period"

"Open Enrollment Period" shall mean the period of time, immediately prior to the annual renewal date, during which an Eligible Person may elect to enroll or change their current coverage. Open Enrollment activity is irrevocable, unless a qualifying event occurs as defined by Section 125 of the IRS Code, even if the Plan is not a qualified plan as defined by Section 125, including but not limited to: loss of coverage due to legal separation, divorce, death of an employee, termination or reduction in hours of employment, exhaustion of COBRA, Dependent reaching maximum age, and moving out of the Plan's service area. Loss of coverage does not include loss due to failure to pay premiums or termination for cause. Qualifying events also include marriage, birth, adoption, placement for adoption and change in the employer contribution.

"Orthosis"
"Orthosis" shall mean a rigid or semi-rigid appliance used for the purpose of supporting a weak or deformed body part or for restricting or eliminating motion in a diseased or injured part of the body.

"Ostomy"
"Ostomy" shall mean an artificial stoma or opening into the urinary tract, gastrointestinal canal or the trachea.

"Ostomy Supplies"
"Ostomy Supplies" shall mean generally non-reusable items or appliances, such as pouches, irrigation equipment and skin barriers, specifically used in the maintenance of hygiene and skin protection in Ostomy patients, ordered by or used on the advice of a healthcare Provider.

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

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third-party;
7. Workers' compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

"Out-of-Area"
"Out of Area" shall mean a geographic area, as determined by the Claims Fiduciary at the time each Participant becomes eligible for coverage under this Plan.

"Out-of-Pocket" or "Out-of-Pocket Maximum"
"Out-of-Pocket" or "Out-of-Pocket Maximum" shall mean a dollar amount paid by the Participant which includes Deductible, Coinsurance, and Copayment amounts. It does not include penalties for failure to obtain Pre-Certification, premiums, amounts in excess of the Allowable Charge, charges for non-Covered Services, and charges after Covered Services have been exhausted, and ancillary fees for a brand-name drug product when a generic equivalent prescription Drug is available for substitution.

"Outpatient"
"Outpatient" shall mean a Participant who receives services or supplies while not an Inpatient.

"Partial Hospitalization Psychiatric Care Services"
"Partial Hospitalization Psychiatric Care Services" shall mean the provision of diagnostic and therapeutic services for the treatment of Mental Illness on an Outpatient basis only during the day or night through a Hospital or Psychiatric

Hospital based program which is approved by the Joint Commission on the Accreditation of Healthcare Organizations.

"Partial Hospitalization Substance Abuse Services"
"Partial Hospitalization Substance Abuse Services" shall mean the provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a Hospital or non-hospital facility licensed by the Department of Health or provide an alcohol or drug addiction treatment program designed for a patient or client who would benefit from more intensive services than are offered in Outpatient treatment but who does not require Inpatient care.

"Participant"
"Participant" shall mean any Employee or Dependent or retiree who is eligible for benefits under the Plan.

Patient Protection and Affordable Care Act (PPACA)"
The "Patient Protection and Affordable Care Act (PPACA)" means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See "Affordable Care Act").

"PerformCare"
"PerformCare" shall mean the Network's dedicated unit that provides utilization management for mental chemical recovery (behavioral health) services.

"Pharmacy Care"
"Pharmacy Care" shall mean medications prescribed by a licensed Physician, licensed Physician Assistant or Certified Registered Nurse Practitioner and any assessment, evaluation or test prescribed or ordered by a licensed Physician, licensed Physician Assistant or Certified Registered Nurse Practitioner to determine the need or effectiveness of such medications.

"Physician"
"Physician" shall mean a person, who is a Doctor of Medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform Surgery and prescribe and administer Drugs.

"Plan Year"
"Plan Year" shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

"Pre-Admission Tests"
"Pre-Admission Tests" shall mean those Diagnostic Services done prior to scheduled Surgery, provided that:

1. The tests are approved by both the Hospital and the Physician;
2. The tests are performed on an Outpatient basis prior to Hospital admission; and
3. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the Surgery.

"Pre-Certification"
"Pre-Certification" shall mean the process whereby a Provider or a Participant, as applicable, is required to obtain certification from First Priority Life for covered services prior to the date of service. Pre-Certification will result in the issuance of a Pre-Certification number or approval by First Priority Life, without which the claim may not be paid. First Priority Life may add or delete services, which require Pre-Certification, as it deems necessary. Any notice of a change shall be considered to have been given when mailed to the Plan and to the Participant at the address on the records of First Priority Life at least thirty (30) days in advance of such change.

“Preferred Provider Organization (PPO)”
“Preferred Provider Organization (PPO)” shall mean an organization that contracts with a Network of Providers from which the health plan Participant can choose. Participants do not need to select a Primary Care Physician (PCP) and do not need referrals to see other Providers in the Network.

“Pregnancy”
“Pregnancy” shall mean carrying a Child, resulting childbirth, miscarriage and non-elective abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

“Pre-negotiated Maximum Allowable Rate”
“Pre-negotiated Maximum Allowable Rate” shall mean any negotiated agreement with a Provider which established a maximum allowable reimbursement for the Plan at a level other than the defined Maximum Allowable Charge. The Pre-negotiated Maximum Allowable Rate must be agreed upon in writing prior to the Participant receiving services from the Provider. Any Provider agreeing to a Pre-negotiated Maximum Allowable Rate must agree to waive all rights to balance bill the Plan or member for any amounts over and above the agreed upon Pre-negotiated Maximum Allowable Rate.

“Preventive Care”
“Preventive Care” shall mean certain Preventive Care services.

This Plan intends to comply with the Affordable Care Act’s (ACA) requirement to offer In-Network coverage for certain preventive services without cost-sharing. To comply with the ACA, and in accordance with the recommendations and guidelines, the Plan will provide In-Network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, Children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/preventive-care-benefits/. For more information, you may contact the Plan Administrator / Employer.

“Primary Care Physician”
“Primary Care Physician” shall mean a Physician, who supervises, coordinates and provides initial care and basic Medical Services to Participant’s as a general or family care practitioner, an internist, or a pediatrician, and maintains continuity of patient care.

“Prior Plan”
“Prior Plan” shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

“Prior to Effective Date” or “After Termination Date”
“Prior to Effective Date” or “After Termination Date” are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges Incurred prior to the effective date of coverage under the Plan or after coverage is terminated.

“Privacy Standards”

"Privacy Standards" shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

"Private Duty Nursing"
"Private Duty Nursing" shall mean total patient care provided by a Registered Nurse or Licensed Practical Nurse on an individual basis.

"Professional Provider"
"Professional Provider" shall mean an individual or practitioner, who is licensed/certified to render covered services. Professional Providers include, but are not limited to:

- Certified Addiction Counselor;
- Clinical Psychologist;
- Chiropractor;
- Clinical Nurse Specialist;
- Dentist;
- Licensed Dietitian;
- Licensed Practical Nurse;
- Nurse Midwife;
- Nurse Practitioner;
- Occupational Therapist;
- Optometrist;
- Physical Therapist;
- Physician;
- Physician Assistant;
- Podiatrist;
- Registered Nurse;
- Clinical Social Worker; and
- Speech Therapist

"Prosthesis"
"Prosthesis" shall mean an artificial body part, which replaces all or part of a body organ or which replaces all or part of the function of a permanently inoperative or malfunctioning body part.

"Provider"
"Provider" shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Third-Party Administrator.

Contracting Provider (Contracting Professional Provider/Contracting Facility Provider) – A Provider who signed a Provider Agreement with First Priority Life and/or is a member of the BlueCard PAR Network.

Non-Contracting Provider (Non-Contracting Professional Provider/Non-Contracting Facility Provider) – A Provider who has not signed a Provider Agreement with First Priority Life and/or who is not a member of the BlueCard PAR Network.

"Provider Agreement"
"Provider Agreement" shall mean an agreement between a Provider and the Plan and/or Highmark Blue Shield, as applicable, or any other Blue Plan pursuant to which negotiated rates are established for payment of covered services rendered to Participant.

“Psychiatric Care”
“Psychiatric Care” shall mean direct or consultative service provided by a Physician who specializes in psychiatry.

“Psychiatric Hospital”
“Psychiatric Hospital” shall mean an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the Diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
3. It is licensed as a Psychiatric Hospital;
4. It requires that every patient be under the care of a Physician; and
5. It provides twenty-four (24) hour a day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

“Psychological Care”
“Psychological Care” shall mean direct or consultative services provided by a Psychologist.

“Psychologist”
“Psychologist” shall mean a licensed clinical Psychologist.

“Qualified Medical Child Support Order” or “QMCSO”
“Qualified Medical Child Support Order” or “QMCSO” is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

“Reasonable”
“Reasonable” and/or “Reasonableness” shall mean in the administrator’s discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Determination that fee(s) or service(s) are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(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. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable 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.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed “reasonably preventable” through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

"Reconstructive Procedure/Surgery"
"Reconstructive Procedure/Surgery" shall mean procedures, including Surgical Procedures, performed on a structure of the body to restore or establish satisfactory bodily function or correct a functionally significant deformity resulting from Disease, Accidental Injury, or a previous therapeutic process. This includes a Surgical Procedure performed on one breast or both breasts following a Mastectomy, as determined by the treating Physician, to reestablish symmetry between the two breasts or alleviate functional impairment caused by the Mastectomy and it includes, but is not limited to: augmentation mammoplasty, reduction mammoplasty and mastopexy.

"Registered Nurse (RN)"
"Registered Nurse (RN)" shall mean a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by appropriate state authority.

"Rehabilitation Hospital"
"Rehabilitation Hospital" shall mean a Facility Provider approved by the appropriate accrediting agency or a similar accrediting agency acceptable to the Plan, which is primarily engaged in providing rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by Disease or Injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided by or under the supervision of a Registered Nurse.

"Rehabilitative Care"
"Rehabilitative Care" shall mean professional services and treatment programs, including Applied Behavioral Analysis, provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.

"Respite Care"
"Respite Care" shall mean Residential Medical Care given in a setting outside the patient's home, such as in a Skilled Nursing Facility, in order to provide a brief interval of relief for the patient's primary caregiver, which is usually a family member.

"Retail Clinic Care"
"Retail Clinic Care" shall mean the treatment of common minor ailments (in a health care facility located in a convenient setting, such as a retail store, grocery store or pharmacy, which offers unscheduled, walk-in care) including, but not limited to, sore throat, coughs or pink eye.

"Room and Board"
"Room and Board" shall mean a Hospital's charge for:

1. Room and linen service;
2. Dietary service, including meals, special diets and nourishment;
3. General nursing service; and
4. Other conditions of occupancy which are Medically Necessary.

"Scheduled Benefit" or "Scheduled Benefit Amount"
"Scheduled Benefit" or "Scheduled Benefit Amount" shall mean a dollar amount that will be considered for reimbursement under the Plan for a particular type of Medical Care, service or supply provided. Scheduled Benefits are based upon Covered Services not otherwise limited or excluded under the terms of the Plan.

“Security Standards”
“Security Standards” shall mean the final rule implementing HIPAA’s Security Standards for the Protection of Electronic PHI, as amended.

“Semi-Private Room”
“Semi-Private Room” shall mean the bed, board and nursing care regularly provided to patients in a room which is designated as semi-private by the Provider of care and which contains more than one bed.

“Serious Mental Illness”
“Serious Mental Illness” shall mean any of the following mental illnesses, as defined by the American Psychiatric Association; schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

“Service Area”
“Service Area” shall mean the following thirteen (13) Pennsylvania counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming.

“Service Waiting Period”
“Service Waiting Period” shall mean an interval of time during which the Employee is in the continuous, Active Employment of his or her Participating Employer.

“Sickness”
“Sickness” shall have the meaning set forth in the definition of “Disease.”

“Skilled Nursing Facility”
“Skilled Nursing Facility” shall mean a Facility Other Provider, which is an Institution or a distinct part of an Institution, other than one which is primarily for the care and treatment of Mental Disorders, alcoholism or drug addiction, which is certified as a Skilled Nursing Facility under the Medicare Law, or is qualified to receive such approval, if so requested.

“Specialist Physician”
“Specialist Physician” shall mean a Physician who provides Medical Care in any generally accepted medical specialty or subspecialty.

“Spouse”
“Spouse” shall mean an Employee’s spouse, under a legally valid existing marriage.

The Plan Administrator has discretionary authority to interpret these terms, and determine spousal status as defined herein, to the extent allowed by law.

“Substance Abuse”
“Substance Abuse” shall mean any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a Drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of “Substance Use Disorder” is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12)-month period:
    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);

   b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
   c. Craving or a strong desire or urge to use a substance; or
   d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with Spouse about consequences of intoxication, physical fights); and
2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

"Substance Abuse Treatment Center"
"Substance Abuse Treatment Center" shall mean an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following: (1) Substance Abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the Drug is needed to achieve the same effect); and (4) withdrawal symptoms.

"Supplier"
"Supplier" shall mean an individual or entity that is in the business of leasing and selling Durable Medical Equipment and supplies, Prostheses and Orthoses.

"Surgery"
"Surgery" shall mean any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilatation and curettage; or
7. Biopsy.

"Surgical Procedure"
"Surgical Procedure" shall have the same meaning set forth in the definition of "Surgery."

"Telemedicine"
"Telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications.

"Therapeutic Care"
"Therapeutic Care" shall mean services provided by Speech Language Pathologists, Occupational Therapists or Physical Therapists.

"Therapy Service"

"Therapy Service" shall mean services or supplies used for the treatment of an Illness or Injury to promote the recovery of a Participant. Therapy Services are covered to the extent specified in the Plan.

1. Cardiac rehabilitation therapy – An exercise program, which is effective in the physiological and psychological rehabilitation of patients with cardiac conditions;
2. Cognitive rehabilitation therapy – A structured set of therapeutic activities designed to retain an individual's ability to think, use judgment and make decisions. The focus is on improving deficits in memory, attention, perception, learning, planning, and judgment. The term, cognitive rehabilitation, is applied to a variety of intervention strategies or techniques that attempt to help patients reduce, manage, or cope with cognitive deficits caused by brain injury;
3. Dialysis treatment – The treatment of acute renal failure or chronic irreversible renal insufficiency or removal of waste materials from the body to include hemodialysis or peritoneal dialysis;
4. Occupational therapy – The treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role;
5. Physical therapy – The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-psychological principles, and devices to relieve pain, restore maximum function, and prevent disability following Disease, Injury or loss of body part performed by a licensed Physical Therapist;
6. Pulmonary rehabilitation therapy – A program of exercise training, psychological support and pulmonary physiotherapy education which is intended to improve the patient's functioning and quality of life by controlling and alleviating symptoms, including complications of pulmonary disorders;
7. Radiation therapy – The treatment of Disease by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes;
8. Respiratory therapy – The introduction of dry or moist gases into the lungs for treatment purposes; and
9. Speech therapy – The treatment for the correction of a speech impairment resulting from Disease, Surgery, Injury, anomalies or previous therapeutic processes.

"Third-Party Administrator"
"Third-Party Administrator" shall mean the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims.

"Total Disability"
"Total Disability" shall mean an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may, in its sole discretion, require.

"Totally Disabled"
"Totally Disabled" shall have the same meaning set forth in the definition of "Total Disability."

"Transitional Living Facility"
"Transitional Living Facility" shall mean a facility that renders Long-Term Residential Care. This type of facility can be licensed, when appropriate, by a state Department of Health. However, a facility providing Long-Term Residential Care is not to be considered an Inpatient Non-Hospital Residential Facility rendering Inpatient Non-Hospital Residential Care. Specific Transitional Living Facilities include half-way houses, group homes or supervised apartment settings.

"Transplant Procedures"
"Transplant Procedures" shall mean the pre-testing and/or initial evaluation and/or consultation processes occurring before as well as leading up to and including Surgery for the transplant of human tissue and/or organs.

"Treatment Plan for ASD"

"Treatment Plan for ASD" shall mean a plan for the treatment of Autism Spectrum Disorders developed by a licensed Physician or licensed Psychologist pursuant to a comprehensive evaluation or re-evaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

"Unattended Services"
"Unattended Services" shall mean services that are not accompanied by a Provider or monitored by a Provider.

"Uniformed Services"
"Uniformed Services" shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

"Urgent Care"
"Urgent Care" shall mean the provision of immediate medical service offering Outpatient care (in a facility dedicated to the delivery of unscheduled, walk-in care outside of a Hospital emergency department) for the treatment of acute and chronic Illness or Injury.

"USERRA"
"USERRA" shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

"Usual and Customary"
"Usual and Customary" (U&C) shall mean Covered Services which are identified by the Third-Party 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. 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 comply 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 the specific service or supply furnished to a Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Claims Fiduciary 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 Claims Fiduciary's or discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ARTICLE IV
ELIGIBILITY FOR COVERAGE

4.01 Eligibility for Individual Coverage

Each Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month following the Employee's date of hire, provided the Employee has begun work for his or her Participating Employer. If the date of hire is the first full working day of the month, benefits will begin upon Active Employment and timely completion of enrollment forms. If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work. Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan.

Special retirement incentive plans, including but not limited to window and phased separation plans, are offered a specific retirement option that may be more generous than the standard retirement benefits. Window retirees are able to elect only within a specific window of time. Documentation of these special agreements will be kept in the Human Resources office at the University of Scranton.

4.01A Reinstatement of Coverage

If employment is terminated and the Employee returns to Active Employment, eligibility for individual coverage will take effect as noted in Section 4.01.

4.01B Eligibility for Retiree Coverage

A staff member of the University of Scranton is considered a "retiree" if they separate from the University meeting at least one of the following criteria:

1. Age sixty-five (65) as defined in the University retirement plans (no minimum service requirement);
2. Age fifty-five (55) through sixty-one (61) with twenty (20) years of service (full or part-time, with two (2) full years of part-time service, exclusive of adjunct teaching service, counting as one year for purposes of this policy;
3. Ages sixty-two (62) through sixty-four (64) with ten (10) years of continuous service (full or part-time, with two (2) full years of part-time service, exclusive of adjunct teaching service, counting as one (1) year for purposes of this policy).

Employees who meet retirement eligibility may remain on group plan coverage as long as they assume the full cost share for the premium for their level of coverage. Also, the eligible retiree's Spouse is eligible to remain on the Plan in the event of the Employee's death, as long as he/she assumes the full cost-share for the premium for his/her level of coverage.

A faculty member is considered a retiree per the age and service requirements outlined in Article 17 of the 2012-2015 Faculty Contract.

"Window" retirees are given opportunity to retire during a specific timeframe outside of the normal retirement requirements. These agreements are specific to the individual and give length of time retiree is allowed to continue on the coverage with applicable cost-share.

4.02 Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan;

2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan; and
3. The first date upon which he or she acquires a Dependent.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

Any reference in this Plan to an Employee's Dependent being covered means that such Employee is covered for Dependent Coverage.

"Michelle's Law" prohibits a group health plan, or a health insurance issuer that provides health insurance coverage in connection with a group health plan, from terminating coverage of a Dependent Child due to a qualifying "Medically Necessary Leave of Absence" from, or other change in enrollment at, a postsecondary educational Institution prior to the earlier of:

1. The date that is one year after the first day of the Medically Necessary Leave of Absence; or
2. The date on which such coverage would otherwise terminate under the terms of the Plan.

In order to be a Medically Necessary Leave of Absence the student's leave must:

1. Commence while the Dependent Child is suffering from a serious Illness or Injury;
2. Be Medically Necessary; and
3. Cause the Dependent Child to lose student status for purposes of coverage under the terms of the parents' plan or coverage.

A Child is a "Dependent Child" under the law if he or she:

1. Is a Dependent Child, under the terms of the Plan or coverage, is a Dependent of a Participant under the Plan or coverage; and
2. Was enrolled in the Plan or coverage, on the basis of being a student at a postsecondary educational Institution, immediately before the first day of the Medically Necessary Leave of Absence.

A treating Physician of the Dependent Child must certify that the Dependent Child is suffering from a serious Illness or Injury and that the Leave of Absence (or other change of enrollment) described is Medically Necessary.

4.03 Effective Dates of Coverage; Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. <u>Enrollment Form.</u> Coverage for an Employee or his or her Dependents must be requested by the Employee on a form furnished by the Plan Administrator and will become effective on the date such Employee or Dependents are eligible, provided the Employee has enrolled for such coverage on a form satisfactory to the Plan Administrator within the thirty (30) day period immediately following the date of eligibility.

2. <u>Birth of Dependent Child.</u> If a Dependent Child is born after the date the Employee's coverage for himself or herself under the Plan becomes effective, coverage shall take effect from and after the moment of birth, to the extent of the benefits provided herein, and any limitations of this Plan with respect to congenital defects shall not apply to such Child. If the Employee does not have coverage under this Plan for any Dependents at the date of such Child's birth, then coverage for such Child shall continue for thirty-one (31) days. After the thirty-one (31) day period, coverage shall continue only if the Employee makes written application to the Plan for such Child and agrees to make any required contribution.

3. Newly Acquired Dependents. If an Employee acquires a Dependent while the Employee is eligible for coverage for Dependents, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible, provided application is made to the Plan within thirty (30) days of the date of eligibility and any required contributions are made.

4. Requirement for Employee Coverage. No coverage for Dependents of an Employee will become effective unless the Employee is, or simultaneously becomes, eligible for coverage for himself or herself under the Plan.

5. Coverage as Both Employee and Dependent. No person may be simultaneously covered under this Plan as both an Employee and a Dependent.

6. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

7. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

4.04 Special and Open Enrollment

The Plan provides special enrollment periods that allow Employees to enroll in the Plan, even if they declined enrollment during an initial or subsequent eligibility period. **This Section 4.04 Special and Open Enrollment does not apply to University Retirees or their eligible dependents.**

4.04A Loss of Other Coverage

If an Employee declined enrollment for himself or herself or his or her Dependents (including his or her Spouse) because of other health coverage, he or she may enroll for coverage for himself or herself and/or his or her Dependents if the other health coverage is lost. The Employee must make written application for special enrollment within thirty (30) days of the date the other health coverage was lost. For example, if the Employee loses his or her other health coverage on September 15, he or she must notify the Plan Administrator and apply for coverage by close of business on October 15.

The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll during this special enrollment period:

1. If the Employee is eligible for coverage under the terms of this Plan;
2. The Employee is not currently enrolled under the Plan;
3. When enrollment was previously offered, the Employee declined because of coverage under another group health plan or health insurance coverage. The Employee must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan; and
4. If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because Employer contributions for the coverage were terminated.

An Employee who is already enrolled in a benefit package may enroll in another benefit package under the Plan if a Dependent of that Employee has a special enrollment right in the Plan because the Dependent lost eligibility for other coverage. The Employee must make written application for special enrollment in the new benefit package within thirty (30) days of the date the other health coverage was lost.

The Employee is not eligible for this special enrollment right if:

1. The other coverage was COBRA continuation coverage and the Employee did not exhaust the maximum time available to him or her for that COBRA coverage; or
2. The other coverage was lost due to non-payment of requisite contribution / premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the Plan.

4.04B New Dependent
If an Employee acquires a new Dependent as a result of marriage, birth, adoption, legal guardianship, or placement for adoption, he or she may be able to enroll himself or herself and his or her Dependents during a special enrollment period.

For new Dependent due to marriage: The Employee must make written application for special enrollment no later than thirty (30) days after he or she acquires the new Dependent. For example, if the Employee is married on September 15, he or she must notify the Plan Administrator and apply for coverage by close of business on October 15.

For new Dependent due to birth, adoption or placement for adoption: The Employee must make written application for special enrollment no later than thirty (30) days after he or she acquires the new Dependent. For example, if the a dependent is born on September 15, he or she must notify the Plan Administrator and apply for coverage by close of business on October 15.

The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll himself or herself and/or his or her eligible Dependents during this special enrollment period if:

1. The Employee is eligible for coverage under the terms of this Plan; and
2. The Employee has acquired a new Dependent through marriage, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for the Employee and his or her Dependent(s) will be effective at 12:01 A.M.:

1. For a marriage, on the first day of the calendar month following enrollment;
2. For a birth, on the date of birth; or
3. For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

4.04C Additional Special Enrollment Rights
Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within sixty (60) days after the termination; or
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within sixty (60) days after eligibility is determined.

3. If the conditions for special enrollment are satisfied, coverage for Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request (including the Participant's enrollment for, in the case of enrollment) is received by the Plan."

4.04D Open Enrollment

Participants may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during an Open Enrollment Period will become effective on at 12:01 a.m. on the first day of the new Plan Year, unless the Employee has not satisfied the Service Waiting Period, in which event coverage for the Employee and his or her Dependents will become effective on the day following completion of the Service Waiting Period.

"Open Enrollment Period" shall mean the set period, as determined by the Plan Administrator, for eligible Participants to add or make changes to their benefits. Plan Participants will receive detailed information regarding Open Enrollment from the Plan Administrator.

4.05 Qualified Medical Child Support Orders

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for Child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical Child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the Child or Children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying Child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

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

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";
2. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;
3. Informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within twenty (20) days, the Child will be enrolled under the Plan's default option (if any); and
4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated Dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
    a. Whether the Child is covered under the Plan; and
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

4.06 Genetic Information Nondiscrimination Act (GINA)

GINA prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

The term “genetic information” means, with respect to any individual, information about:

1. Such individual’s genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a Disease or disorder in family members of such individual.

The term “genetic information” includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include Dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

4.07 Late Enrollee:

“Late Enrollee” shall mean a Participant who enrolls in the Plan other than:

1. On the earliest date of which coverage can become effective for the individual under the terms of the Plan;
   or
2. Through special enrollment.

ARTICLE V
TERMINATION OF COVERAGE

5.01 Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates unless prohibited by law:

1. The last day of the month following termination of the Plan;
2. The last day of the month in, or with respect to which, he or she requests that such coverage be terminated, provided such request is made on or before such date;
3. The last day of the month for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing;
4. The last day of the month in which he or she ceases to be eligible for such coverage under the Plan;
5. The last day of the month in which the termination of employment occurs; or
6. The last day of the month in which an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

5.01A Termination Dates of Retiree Coverage

The coverage of any retiree who is covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. The date of death of the covered retiree;
3. The date of the expiration of the last period for which the retiree has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing; or
4. The date a covered retiree voluntary disenrolls from the Plan. A retiree who voluntary disenrolls is not eligible to reenroll at a later date.

Retirees who have not reached the eligibility age for Medicare can remain on the Plan if they pay their full premiums. When Medicare eligibility is reached, the retiree Participant will be transferred to Signature 65 coverage.

5.02 Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The last day of the month following termination of the Plan;
2. The last day of the month upon the discontinuance of coverage for Dependents under the Plan;
3. The last day of the month of termination of the Employee’s coverage for himself or herself under the Plan;
4. The last day of the month for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing;
5. In the case of a Child age twenty-six (26) or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, coverage will terminate on the last day of the month, on the earliest to occur of:
    a. Cessation of such inability;
    b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
    c. Upon the Child’s no longer being dependent on the Employee for his or her support;
6. The last day of the month such person ceases to be a Dependent, as defined herein, except as may be provided for in other areas of this section;

7. The last day of the month that an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information; or
8. The date the Dependent of a retiree voluntary disenrolls from the Plan. A Dependent of a retiree who voluntary disenrolls is not eligible to reenroll at a later date.

ARTICLE VI
CONTINUATION OF COVERAGE

6.01 Employer Continuation Coverage

Coverage will be continued for eligible Participants should the following occur:

1. Total Disability:
    a. FACULTY: When a faculty Employee is on Short Term Disability leave, the Plan provides full benefit continuation for up to six (6) months. Employees have continued responsibility for usual deductions, including deductions for health insurance. When a faculty Employee is on Long Term Disability leave, the Plan provides full benefit continuation at the Employee share of the premium for up to thirty (30) months as long as the Employee continues to pay the appropriate cost-sharing. After the 30 months, the faculty member may continue to purchase health insurance, provided the individual pays 100% of the applicable premium.
    b. STAFF: When a staff Employee is on Short Term Disability leave, the Plan provides full benefit continuation for up to six (6) months as long as the Employee pays the Employee share of the premium. When the Employee is on Long Term Disability leave, health insurance will be extended for an additional thirty (30) months as long as the Employee continues to pay the appropriate cost-sharing. After the 30 months, a qualified retiree may continue to purchase health insurance, provided the individual pays 100% of the applicable premium.
2. Leave of Absence:
    a. FACULTY: Approved Leaves of Absence allow Employees to continue on benefits with payment of full cost contribution from Employee up to one (1) year. Approved sabbaticals allow Employees to continue with full benefits continuation with the same active cost-share contribution from the Employee and University of Scranton as prior to the sabbatical.
    b. STAFF: Approved Leaves of Absence allow Employees to continue on benefits for up to three (3) months with payment of full cost contribution from Employee and Plan as prior to the Leave of Absence.

6.02 Continuation During Family and Medical Leave Act (FMLA) Leave

Regardless of the established leave policies mentioned above, the Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Employee will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

6.02A Family and Medical Leave Act of 1993 (FMLA)

This applies to Employers with fifty (50) or more Employees for at least twenty (20) workweeks in the current or preceding Calendar Year. The following are some definitions identified by the FMLA:

Covered Service Member

"Covered Service Member" shall mean current service members and covered veterans who are undergoing medical treatment, recuperation, or therapy due to a serious Injury or Illness, rather than just current service members. A covered veteran is an individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to when the eligible Employee takes FMLA Leave to care for the covered veteran.

Eligible Employee

"Eligible Employee" shall mean an individual who has been employed by the Company for at least twelve (12) months, has performed at least one thousand two hundred fifty (1,250) hours of service during the previous twelve (12) month period, and has worked at a location where at least fifty (50) Employees are employed by the Employer within seventy-five (75) miles.

Family Member
"Family Member" shall mean the (a) Employee's biological, step, or foster parent or (b) a natural, adopted, foster, or stepchild, or a legal ward under eighteen (18) years of age, or eighteen (18) years and older and incapable of self-care because of a mental or physical disability or (c) Spouse.

Serious Illness or Injury (of a service member or covered veteran)
"Serious Illness or Injury" shall mean an Illness or Injury Incurred in the line of duty that may render the service member medically unfit to perform his or her military duties. A serious Injury or Illness for a current service member includes an Injury or Illness that existed before the beginning of the service member's active duty and was aggravated by service in the line of duty on active duty in the armed forces. A serious Injury or Illness for a covered veteran means an Injury or Illness that was Incurred or aggravated by the service member in the line of duty on active duty in the armed forces and manifested itself before or after the service member became a veteran.

These definitions are listed as a guide and the actual wording of the FMLA, as amended, shall supersede these definitions.

6.02B Basic Leave Entitlement
FMLA requires covered Employers to provide up to twelve (12) weeks of unpaid, job-protected leave to eligible Employees for the following reasons:

1. For incapacity due to Pregnancy, prenatal Medical Care or Childbirth;
2. To care for the Employee's Child after birth, or placement for adoption or foster care;
3. To care for the Employee's Spouse, son, daughter or parent, who has a serious health condition; or
4. For a serious health condition that makes the Employee unable to perform the Employee's job.

6.02C Military Family Leave Entitlements
Eligible Employees whose Spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their twelve (12) week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible Employees to take up to twenty-six (26) weeks of leave to care for a covered service member during a single twelve (12) month period. A covered service member is:

(1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in Outpatient status, or is otherwise on the temporary disability retired list, for a serious Injury or Illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible Employee takes FMLA Leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious Injury or Illness.*

***The FMLA definitions of "serious Injury or Illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".**

6.02D Benefits and Protections
During FMLA Leave, the Employer must maintain the Employee's health coverage under any "group health plan" on the same terms as if the Employee had continued to work. Upon return from FMLA Leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA Leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

6.02E Eligibility Requirements

Employees are eligible if they have worked for a covered Employer for at least twelve (12) months, have one thousand two hundred fifty (1,250) hours of service in the previous twelve (12) months*, and if at least fifty (50) Employees are employed by the Employer within seventy-five (75) miles.

***Special hours of service eligibility requirements apply to airline flight crew Employees.**

6.02F Definition of Serious Health Condition

A serious health condition is an Illness, Injury, impairment, or physical or mental condition that involves either an overnight stay in a Medical Care facility, or continuing treatment by a health care Provider for a condition that either prevents the Employee from performing the functions of the Employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three (3) consecutive calendar days combined with at least two (2) visits to a health care Provider or one (1) visit and a regimen of continuing treatment, or incapacity due to Pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

6.02G Use of Leave

An Employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when Medically Necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the Employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

6.02H Substitution of Paid Leave for Unpaid Leave

Employees may choose or Employers may require use of accrued paid leave while taking FMLA Leave. In order to use paid leave for FMLA Leave, Employees must comply with the Employer's normal paid leave policies.

6.02I Employee Responsibilities

Employees must provide thirty (30) days advance notice of the need to take FMLA Leave when the need is foreseeable. When thirty (30) days' notice is not possible, the Employee must provide notice as soon as practicable and generally must comply with an Employer's normal call-in procedures.

Employees must provide sufficient information for the Employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the Employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care Provider, or circumstances supporting the need for military family leave. Employees also must inform the Employer if the requested leave is for a reason for which FMLA Leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

6.02J Employer Responsibilities

Covered Employers must inform Employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the Employees' rights and responsibilities. If they are not eligible, the Employer must provide a reason for the ineligibility.

Covered Employers must inform Employees if leave will be designated as FMLA-protected and the amount of leave counted against the Employee's leave entitlement. If the Employer determines that the leave is not FMLA-protected, the Employer must notify the Employee.

6.02K Unlawful Acts by Employers

FMLA makes it unlawful for any Employer to:

1. Interfere with, restrain, or deny the exercise of any right provided under FMLA; and
2. Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

6.02L Enforcement

An Employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an Employer.

FMLA does not affect any Federal or State law prohibiting discrimination or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered Employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.
For additional information:
1 (866) 4US-WAGE, 1 (866) 487-9243; TTY: 1 (877) 889-5627
WWW.WAGEHOUR.DOL.GOV
U.S. Department of Labor Wage and Hour Division
WHD Publication 1420 · Revised February 2013

6.03 Continuation During USERRA

Participants who are absent from employment because they are in the Uniformed Services may elect to continue their coverage under this Plan for up to twenty-four (24) months. To continue coverage, Participants must comply with the terms of the Plan, including election during the Plan's annual enrollment period, and pay their contributions. Contributions for those on leave for the first six months would be at the employee's cost with months 7-24 at full cost share. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their Contracting Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

6.04 Continuation During COBRA – Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participants family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if the Participant or their covered Dependents fail to make timely payment of contributions or premiums. Participants should check with their Employer to see if COBRA applies to them and/or their covered Dependents.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Additionally, the Participant may qualify for a thirty (30)-day special enrollment period for another

group health plan for which the Participant is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

6.04A COBRA Continuation Coverage

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long term disability benefits (if a part of the Employer's plan) are not considered for continuation under COBRA.

6.04B Qualifying Events

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Participant." The Employee, the Employee's Spouse, and the Employee's Dependent Children could become Qualified Participants if coverage under the Plan is lost because of the Qualifying Event.

A covered Employee (meaning an Employee covered under the Plan) will become a Qualified Participant if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced; or
2. The employment ends for any reason other than gross misconduct.

The Spouse of a covered Employee will become a Qualified Participant if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The Spouse dies;
2. The Spouse's hours of employment are reduced;
3. The Spouse's employment ends for any reason other than his or her gross misconduct;
4. The Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The Spouse becomes divorced from his or her Spouse.

Dependent Children will become Qualified Participants if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies;
2. The parent-covered Employee's hours of employment are reduced;
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced; or
6. The Child stops being eligible for coverage under the Plan as a Dependent Child.

If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of any retired Employee, Spouse, surviving Spouse, and Dependent Children covered under the Plan, such member will become a Qualified Participant with respect to the bankruptcy.

6.04C Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event.

6.04D Employee Notice of Qualifying Events

Each covered Employee or Qualified Participant is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce of a covered Employee (or former Employee) from his or her Spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Participant has become entitled to COBRA Continuation Coverage with a maximum duration of eighteen (18) (or twenty-nine (29)) months;
4. Notice that a Qualified Participant entitled to receive Continuation Coverage with a maximum duration of eighteen (18) months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first sixty (60) days of Continuation Coverage; and
5. Notice that a Qualified Participant, with respect to whom a notice described above has been provided has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

University of Scranton
800 Linden Street
Scranton, PA 18510-4679
Phone: (570) 941-7767
Fax: (570) 941-4636

A form of notice is available, free of charge, from the Plan Administrator and must be used when providing the notice.

6.04E Deadline for providing the notice

For Qualifying Events described above, the notice must be furnished by the date that is sixty (60) days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described above, the notice must be furnished by the date that is sixty (60) days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first eighteen (18) months of Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is thirty (30) days after the later of:

1. The date of the final determination by the SSA that the Qualified Participant is no longer disabled; or
2. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed) or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial eighteen (18) month COBRA coverage period.

6.04F Who Can Provide the Notice

Any individual who is the covered Employee (or former Employee), a Qualified Participant with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Participant, may provide the notice, and the provision of notice by one (1) individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Participants with respect to the Qualifying Event.

6.04G Required Contents of the Notice

The notice must contain the following information:

1. Name and address of the covered Employee or former Employee;
2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period;
3. A description of the Qualifying Event (for example, divorce, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Participant or loss of disability status);
4. In the case of a Qualifying Event that is divorce, name(s) and address(es) of Spouse and Dependent Child(ren) covered under the Plan, date of divorce, and a copy of the decree of divorce;
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of Spouse and Dependent Child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age, lost student status or other);
7. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of Spouse and Dependent Child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Participant, name and address of the disabled Qualified Participant, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Participant who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within thirty (30) days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Participants, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

6.04H Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within fourteen (14) days of receiving the notice of the Qualifying Event. The individual then has sixty (60) days in which to elect COBRA Continuation Coverage. The sixty (60) day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that sixty (60) day period, then the right to elect it ceases.

Each Qualified Participant will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their Children.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

6.04I Duration of COBRA Continuation Coverage

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than thirty-six (36) months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the thirty-six (36) month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of thirty-six (36) months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than eighteen (18) months before the Qualifying Event, COBRA Continuation Coverage for Qualified Participants other than the covered Employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight (8) months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her Spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the Qualifying Event (thirty-six (36) months minus eight (8) months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of eighteen (18) months. There are two (2) ways in which this eighteen (18) month period of COBRA Continuation Coverage can be extended.

6.04J Disability Extension of COBRA Continuation Coverage

If an Employee or anyone in an Employee's family covered under the Plan is determined by the SSA to be disabled and the Employee notifies the Plan Administrator as set forth above, the Employee and his or her entire family may

be entitled to receive up to an additional eleven (11) months of COBRA Continuation Coverage, for a total maximum of twenty-nine (29) months. The disability would have to have started at some time before the sixtieth (60th) day of COBRA Continuation Coverage and must last at least until the end of the eighteen (18) month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

6.04K Second Qualifying Event Extension of COBRA Continuation Coverage

If an Employee's family experiences another Qualifying Event while receiving eighteen (18) months of COBRA Continuation Coverage, the Spouse and Dependent Children in the family can get up to eighteen (18) additional months of COBRA Continuation Coverage, for a maximum of thirty-six (36) months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the Spouse and any Dependent Children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

6.04L Shorter Duration of COBRA Continuation Coverage

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date the Employer ceases to provide a group health plan to any Employee;
2. The date on which coverage ceases by reason of the Qualified Participant's failure to make timely payment of any required contributions or premium;
3. The date that the Qualified Participant first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules); or
4. The first day of the month that begins more than thirty (30) days after the date of the SSA's determination that the Qualified Participant is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

6.04M Contribution and/or Premium Requirements

Once COBRA Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within forty-five (45) days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within thirty (30) days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

6.05 Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator, who is:

University of Scranton
800 Linden Street
Scranton, PA 18510-4679
Phone: (570) 941-7767
Fax: (570) 941-4636

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified above. For more information about a Participant's rights under the Employee Retirement Income Security Act (ERISA), including COBRA, HIPAA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

6.06 Current Addresses

In order to protect the rights of the Employee's family, the Employee should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

ARTICLE VII
GENERAL AND MEDICAL LIMITATIONS AND EXCLUSIONS

This section applies to all benefits provided under any section of this Plan. This Plan does not cover any charge for care, supplies, treatment, and/or services:

1. That are not prescribed by or performed by or under the direction of a Physician or Professional Provider within the scope of licensure;

2. That are not Medically Necessary, except those that are provided within the Plan for Preventive Care or those mandated by law;

3. That are rendered by other than, professional providers, hospitals or facility other providers;

4. That First Priority Health initially determines are Experimental or Investigational and the covered services related to them; the fact that a treatment, procedure, equipment, drug, device or supply is the only available treatment for a particular condition will not result in coverage if the service is considered to be Experimental or Investigational. Coverage will not be provided for services related to medical research;

5. For any Illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of Workers' Compensation, occupational disease or similar type legislation. The exclusion applies whether or not the Participant claims the benefits or compensation;

6. For any Illness or Injury suffered after the Participant's Effective Date of coverage as a result of any act of war;

7. For which a Participant would have no legal obligation to pay;

8. That are received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;

9. That are provided for active military personnel by the Veteran's Administration or by the Department of Defense;

10. For cosmetic purposes done to improve the appearance of any portion of the body and from which no improvement in physiologic function can be expected, except as otherwise required by law, and removal of port wine lesions, except when involving the visible portion of the face. However, covered services are payable to correct a cosmetic condition directly resulting from an Accident. Covered services are also payable to correct functional impairment which results from a covered Disease, Injury, or congenital birth defect;

11. That incurred prior to the Participant's effective date or during an inpatient admission that commenced prior to the participant's effective date except, however, covered services shall be provided during that inpatient admission for a condition that commenced on or after the effective date of coverage;

12. That Incurred after the date of termination of the Participant's coverage;

13. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, whether or not prescribed by a Physician;

14. For telephone consultations between a Provider and the Participant, charges for failure to keep a scheduled visit with a Provider, or charges for completion of a Provider's claim form;

15. For Inpatient Admissions which are primarily for Diagnostic Services which could have been performed on an Outpatient basis;

16. For custodial care, domiciliary care or rest cures;

17. For Inpatient admissions which are primarily for Therapy Services which could have been performed on an Outpatient basis;

18. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;

19. For screening examinations except as specifically provided in the Medical Benefits section;

20. That are directly related to the care, filling, removal or replacement of teeth, the treatment of Injuries to or Diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to: apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates, as specifically provided for and defined in the Medical Benefits section;

21. For hearing aids or examinations for the prescription or fitting of hearing aids;

22. For the correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;

23. For any treatment leading to or in connection with transsexual surgery, except for Sickness or Injury resulting from Surgery;

24. For services related to treatment provided specifically for the purpose of assisted fertilization; including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law;

25. That are related to the non-surgical, medical treatment of obesity including but not limited to, dietary supplements or programs for weight reduction;

26. For which payment has been made under Medicare or would have been made if the Participant had applied for Medicare and claimed Medicare benefits; however, this exclusion shall not apply when the Plan is obligated by law to offer the Participant all the covered services of the Plan and the Participant so elects this coverage as primary;

27. For treatment of sexual dysfunction not related to organic Disease or Injury;

28. For assisted fertilization techniques such as, but not limited to, artificial insemination, in-vitro fertilization (IVF), gamete intra fallopian transfer (GIFT), and zygote intra fallopian transfer (ZIFT);

29. For Injuries resulting from the use or maintenance of a motor vehicle if such services are paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable by the Catastrophic Loss Trust Fund established under the Pennsylvania Motor Vehicle Financial Responsibility Law;

30. For admissions or treatment not certified as eligible under the Pre-Certification requirements of the Plan, as listed in the Summary of Benefits, when such certification is required by the Participant;

31. For routine neonatal circumcision;

32. For services payable under any other group Plan;

33. That are recoverable by or on behalf of the Participant in any action at law or in compromise or settlement of a claim against a party, other than an insurer of the Participant, unless the Participant furnished such information as the Plan may require to facilitate enforcement of its rights;

34. That exceed the Provider's Reasonable charge;

35. For treatment of temporomandibular joint (TMJ) except for surgical treatment for the total reconstruction or replacement of a completely degenerated joint;

36. For equipment costs related to services performed on high-cost technological equipment as defined by Blue Shield, such as, but not limited to, computed tomography (CT) scanners; magnetic resonance imagers (MRI) and extracorporeal shock wave lithotripters, unless the acquisition of such equipment by a Professional Provider was approved through the Certificate of Need (CON) process and/or by Blue Shield;

37. For local infiltration anesthetic;

38. That are performed in a facility by a Professional Provider who in any case is compensated by the facility for similar services performed for patients;

39. That are performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training;

40. For eyeglasses or contact lenses and the vision examination for prescribing or fitting. However, following operations for cataracts, charges for initial replacement of eye lens either by contact lens or by lenses in frames will be considered a covered medical expense, but not charges for cataract sunglasses;

41. That are submitted by a certified Registered Nurse and another Professional Provider for the same services performed on the same date for the same patient;

42. For Therapy Services without documented expectation in improvement in level of function;

43. For services as a result of Injuries sustained during the commission of or attempt to commit a felony or to which a contributing cause was the Participant's engagement in an illegal occupation;

44. For otherwise covered services ordered by a court or other tribunal as part of the Participant's or Dependent's sentence;

45. For self-administrable Outpatient prescription Drugs or any Deductible, Copayment or Coinsurance required under any prescription program; however, this exclusion does not apply to Drugs that require Physician administration or for any Drugs that are mandated to be covered by law;

46. For oral surgery for the removal of bony impacted teeth, including any and all Hospital and anesthesia charges;

47. For screenings, other than those specifically listed in the Preventive Care benefit or recommended by the U.S. Preventive Services Task Force (USPSTF);

48. For panniculectomies.

49. Charges in connection with surrogate parenting;

50. Travel or transportation expenses, even though prescribed by a physician, except ambulance service as outline in the Medical Benefits section for the purpose of travel.

51. Smoking cessation aids, except for those Prescription Drugs and smoking cessation aids specifically designated as covered by the Plan's Prescription Drug Formulary or the Preventive Schedule

52. For any care that is related to conditions such as hyperkinetic syndromes, learning disabilities, behavioral problems or intellectual disabilities, but not including care related to Autism Spectrum Disorders, which extends beyond traditional medical management or for Inpatient confinement for environmental change. Care which extends beyond traditional medical management or for Inpatient confinement for environmental change includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modification and/or training; d) services related to the treatment of learning disorders or learning disabilities; e) services provided primarily for social or environmental change or for Respite Care; and f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the Member has not yet attained.

53. For any care that is related to Autism Spectrum Disorders which extends beyond traditional medical management. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; and c) services provided primarily for Respite Care. For purposes of the foregoing, "Autism Spectrum Disorders" means any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

54. Direct pregnancy termination services.

ARTICLE VIII
PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third-Party Administrator to provide certain claims processing and other technical services. Subject to the claims processing and other technical services delegated to the Third-Party Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

8.01 Plan Administrator and Claims Fiduciary

The Plan is administered by the Plan Administrator within the purview of ERISA, and in accordance with applicable law. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

Notwithstanding any provisions of this Summary Plan Description to the contrary, the Plan Sponsor has the authority to, and hereby does, allocate certain fiduciary responsibility to Highmark Blue Cross Blue Shield (the "Claims Fiduciary" or "CF"). The fiduciary responsibility allocated to the CF is limited to discretionary authority and ultimate decision-making authority with respect to any appeals of denied claims, which shall be referred to the CF by the Plan Administrator (the "Referred Appeals"). The CF shall have no authority, responsibility or liability other than with respect to the Referred Appeals.

The Plan Administrator shall establish the policies, practices and procedures of this Plan. The Plan Administrator and the Claims Fiduciary shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator and the Claims Fiduciary shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise relative to a Plan participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator and/or the Claims Fiduciary as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator or the Claims Fiduciary decides, in its discretion, that the Plan participant is entitled to them.

8.02 Duties of the Plan Administrator and Claims Fiduciary

Duties of the Plan Administrator:

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant’s rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a Third-Party Administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO;

11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Duties of the Claims Fiduciary:

The Claims Fiduciary shall have the following duties with respect to the Referred Appeals:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
4. To make factual findings;
5. To decide disputes, which may arise relative to a Plan Participant's rights;
6. To review Referred Appeals and to uphold or reverse any denials; and
7. To keep and maintain records pertaining to the Referred Appeals.

The duties of the CF shall be limited to those set forth above.

8.03 Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any).

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable Federal and State law. Notice shall be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion.

If the Plan is terminated, the rights of the Participants are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

8.04 Summary of Material Reduction (SMR)

A Material Reduction generally means any modification that would be considered by the average Participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or Copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than sixty (60) days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The sixty (60) day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next ninety (90) days.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

8.05 Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within two hundred ten (210) days after the close of the Plan Year in which the changes became effective.

Note: The Affordable Care Act (ACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Participants at least sixty (60) days before the effective date of the Material Modification.

8.06 Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered Participant of the Family Unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

ARTICLE IX
CLAIM PROCEDURES; PAYMENT OF CLAIMS

The procedures outlined below must be followed by Participants to obtain payment of health benefits under this Plan.

9.01 Health Claims

All claims and questions regarding health claims should be directed to the Third-Party Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document has been delegated by the Plan Sponsor to the Claims Fiduciary (CF). The fiduciary responsibility allocated to the CF is limited to discretionary authority and ultimate decision-making authority with respect to any appeals of denied claims.

Each Participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Participant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Participant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Adverse Benefit Determination. If the Participant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Participant then has the right to request an independent external review. The external review procedures are described below.

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

Benefits will be payable to a Participant, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post service. However, as noted below, because of this Plan's design, there are no Pre-service Urgent Care Claims which may be filed with the Plan.

1. Pre-service Claims. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining Medical Care. However, if the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

A "Pre-service Urgent Care Claim" is any claim for Medical Care or treatment with respect to which the application of the time periods for making non Urgent Care determinations could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If a Participant needs Medical Care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

The Plan does not require the Participant to obtain approval of any Urgent Care or Emergency Medical Services or admissions prior to getting treatment for an Urgent Care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Participant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim;

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

   a. The Plan determines that the course of treatment should be reduced or terminated; or
   b. The Participant requests extension of the course of treatment beyond that which the Plan has approved.

   If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim; and

3. Post-service Claims. A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

9.01A When Claims Must Be Filed

Post-service health claims must be filed with the Third-Party Administrator within three hundred sixty five (365) days of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Claims filed later than that date shall be denied.

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third-Party Administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Third-Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Third-Party Administrator within forty-five (45) days from receipt by the Participant of the request for additional information. Failure to do so may result in claims being declined or reduced.

9.01B Timing of Claim Decisions

The Claims Fiduciary shall notify the Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims:
    a. If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim;
    b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than seventy-two (72) hours after receipt of the claim;
    c. The Participant will be notified of a determination of benefits as soon as possible, but not later than seventy-two (72) hours, taking into account the medical exigencies, after the earliest of:
        i. The Plan's receipt of the specified information; or
        ii. The end of the period afforded the Participant to provide the information;
    d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

2. Pre-service Non-urgent Care Claims:
    a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period; and
    b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

3. Concurrent Claims:
    a. Plan Notice of Reduction or Termination. If the Third-Party Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation;
    b. Request by Participant Involving Urgent Care. If the Third-Party Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than twenty-four (24) hours after receipt of the claim, as long as the Participant makes the request at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe;

c. Request by Participant Involving Non-Urgent Care. If the Third-Party Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim); and
d. Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:
   i. Notification to Participant — thirty (30) days
   ii. Notification of Adverse Benefit Determination on appeal — thirty (30) days

4. Post-service Claims:
   a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than thirty (30) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period;
   b. If such an extension is necessary due to a failure of the Participant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Participant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information;
   c. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Third-Party Administrator and the Participant.
      i. Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care claims;
      ii. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to fifteen (15) days, provided that the Third-Party Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial fifteen (15) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision; and
      iii. Extensions – Post-service Claims. This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial thirty (30)-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision; and

5. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

9.01A 9.01C Notification of an Adverse Benefit Determination

The Third-Party Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of pre-service Urgent Care claims, by telephone, facsimile or similar method, with written or electronic notice following within three (3) days), containing the following information:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based;

3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Participant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review;
6. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;
7. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Participant, free of charge, upon request);
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided to the Participant, free of charge, upon request; and
10. In a claim involving Urgent Care, a description of the Plan's expedited review process.

9.02 Appeal of Adverse Benefit Determinations

9.02A Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. Participants at least one hundred eighty (180) days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
2. Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process;
4. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
5. For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
7. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
8. That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Third-Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule,

guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and

8. That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale.

9.02B Requirements for Appeal

The Participant must file the appeal in writing (although oral appeals are permitted for pre-service Urgent Care claims) within one hundred eighty (180) days following receipt of the notice of an Adverse Benefit Determination. For pre-service Urgent Care claims, if the Participant chooses to orally appeal, the Participant may telephone:

Highmark Blue Cross Blue Shield
19 North Main Street
Wilkes-Barre, PA 18711
Phone: 1 (800) 829-8599; 1 (866) 280-0486 (TTY)

To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

Highmark Blue Cross Blue Shield
19 North Main Street
Wilkes-Barre, PA 18711
Phone: 1 (800) 829-8599; 1 (866) 280-0486 (TTY)

It shall be the responsibility of the Participant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Participant;
2. The Employee/Participant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

9.02C Timing of Notification of Benefit Determination on Review

The Third-Party Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

1. <u>Pre-service Urgent Care Claims</u>: As soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the appeal;
2. <u>Pre-service Non-urgent Care Claims</u>: Within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receipt of the appeal;

3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service; and
4. Post-service Claims: Within a reasonable period of time, but not later than sixty (60) days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

9.02D Manner and Content of Notification of Adverse Benefit Determination on Review

The Third-Party Administrator shall provide a Participant with notification, with respect to pre-service Urgent Care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A reference to the specific portion(s) of the plan provisions upon which a denial is based;
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;
4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
5. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
6. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;
7. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;
8. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
9. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

9.02E Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Third-Party Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

9.02F Decision on Review

If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Third-Party Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

9.02G External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

1. An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth (5th) month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five (5) Business Days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
    a. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
    c. The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations;
    d. The claimant has provided all the information and forms required to process an external review. Within one (1) Business Day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 1 (866) 444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external

review with the four-month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Third-Party Administrator to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
    a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
    b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external

review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

9.02H Deemed Exhaustion of Internal Claims Procedures and De Minimis
Exception to the Deemed Exhaustion Rule

A Participant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Participant may proceed immediately to the External Review Program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Participant must adhere to them before participating in the External Review Program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Participant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Participant, and the violation is not reflective of a pattern or practice of non-compliance.

If a Participant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Participant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten (10) days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Participant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

9.03 Appointment of Authorized Representative
A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An Assignment of Benefits by a Participant to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Administrator or the Third-Party Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Participant's medical condition to act as the Participant's authorized representative without completion of this form. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

9.04 Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Participant whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

9.05 Autopsy
The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

9.06 Payment of Benefits
All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or Institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

9.06A Assignments

Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Benefits due to any Network Provider will be considered "assigned" to such Provider and will be paid directly to such Provider, whether or not a written Assignment of Benefits was executed. Notwithstanding any assignment or non-Assignment of Benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

9.06B Non U.S. Providers

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

1. Benefits may not be assigned to a Non U.S. Provider;
2. The Participant is responsible for making all payments to Non U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;
4. The Non U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
5. Claims for benefits must be submitted to the Plan in English.

9.06C Recovery of Payments

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

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

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

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

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

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

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Participant fails to comply with the Plan's third-party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Participant or by any of his covered Dependents if such payment is made with respect to the Participant or any person covered or asserting coverage as a Dependent of the Participant.

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

9.06D Medicaid Coverage

A Participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be subject to the State's

right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

9.06E Limitation of Action

A Participant cannot bring any legal action against the Company or the Third-Party Administrator to recover reimbursement until ninety (90) days after the Plan Participant has properly submitted a request for reimbursement as described in this section and all required reviews of the Plan Participant's claim have been completed. If the Plan Participant wants to bring a legal action against the Company or the Third-Party Administrator, he/she must do so within three (3) years from the expiration of the time period in which a request for reimbursement must be submitted or he/she loses any rights to bring such an action against the Company or the Third-Party Administrator.

A Participant cannot bring any legal action against the Company or the Third-Party Administrator for any other reason unless he/she first completes all the steps in the appeal process described in this section. After completing that process, if he/she wants to bring a legal action against the Company or the Third-Party Administrator he/she must do so within three (3) years of the date he/she is notified of the final decision on the appeal or he/she will lose any rights to bring such an action against the Company or the Third-Party Administrator.

ARTICLE X
COORDINATION OF BENEFITS

10.01 Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of this Plan.

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

The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third-party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

10.03 Vehicle Limitation
When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy Deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

10.04 Allowable Charges
"Allowable Charges" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations section, this Plan's Allowable Charges shall in no event exceed the Other Plan's Allowable Charges. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

In the case of a Non-Preferred Participating Professional Provider, the Allowable Charge is based on the payment/rate that the Host Blue passes on to First Priority Life, or the billed amount, whichever is less. With the exception of Outpatient Emergency Services[2], the Participant will be liable for any Non-Preferred Participating Professional Provider Deductibles or Coinsurance, or Copayments. The Participant will also be responsible for amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

In the case of a Non-Preferred Professional Provider, the Allowable Charge is the same amount First Priority Life would pay to a Preferred Provider, or is the billed amount, whichever is less, with the exception of Outpatient Emergency Services[2]. The Participant is liable for charges that exceed the Allowable Charge, with the exception of Outpatient Emergency Services. The Participant is also liable for any Non-Preferred Professional Provider Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

In the case of a Preferred Facility Provider, the Allowable Charge is established by a Provider Agreement pertaining to payment for Covered Services and will be accepted by the Preferred Facility Provider as payment in full for

Covered Services. The Participant is liable for any Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

In the case of a Non-Preferred Participating Facility Provider, the Allowable Charge is the payment/rate that the Host Blue passes on to First Priority Life or the billed amount, whichever is less. With the exception of Outpatient Emergency Services[1], the Participant is liable for any Non-Preferred Participating Facility Provider Deductibles, Coinsurance, or Copayments. The Participant is also responsible for amounts exceeding any Benefit Maximum, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

In the case of a Non-Preferred Facility Provider, the Allowable Charge is the same amount First Priority Life would pay for services received by a Preferred Facility Provider, or the billed amount, whichever less, with the exception of Outpatient Emergency Services[2]. The Participant is liable for charges that exceed the Allowable Charge, with the exception of Outpatient Emergency Services. The Participant is also liable for any Non- Preferred Facility Provider Deductibles, Coinsurance, Copayments, amounts exceeding any Benefit Maximums, amounts exceeding any Lifetime Maximums, charges after Covered Medical Expenses have been exhausted, and charges for non-Covered Services.

10.05 "Claim Determination Period"

"Claim Determination Period" shall mean each Calendar Year.

10.06 Effect on Benefits

10.06A Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to one hundred percent (100%) of the total Allowable Charges. When there is a conflict in the rules, this Plan will never pay more than fifty percent (50%) of Allowable Charges when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan Deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

10.06B Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan;

[2] In the event that the Participant received Outpatient Emergency Services by a Non-Preferred Participating/Non-Preferred Provider, Highmark Blue Cross Blue Shield will provide coverage at the Preferred Provider level and the Participant's Out-Of-Pocket expenses will be no greater than the amount that would have been incurred if a Preferred Provider had been used.

2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a Dependent, shall be determined before the benefits of a plan which covers such person as a Dependent;
3. If the person for whom claim is made is a Dependent Child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    a. When the parents are separated or divorced, and the parent with the custody of the Child has not remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a Dependent of the parent without custody; or
    b. When the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a Dependent of the stepparent, and the benefits of a plan which covers that Child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a Dependent of the parent without custody.

   Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the Child as a Dependent Child; and
4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.
5. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

10.07 Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

10.08 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

10.09 Right of Recovery

In accordance with section 9.06C, the Recovery of Payments provision , whenever payments have been made by this Plan with respect to Allowable Charges in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Charges, and any future benefits payable to the Participant or his or her Dependents. Please see 9.06C the Recovery of Payments provision above for more details.

ARTICLE XI
MEDICARE

11.01 Applicable to Active Employees and Their Spouses Ages Sixty-Five (65) and Over

An active Employee and his or her Spouse (ages sixty-five (65) and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

11.02 Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). The Participant will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Participant has enrolled for the full coverage. If the Provider accepts assignment with Medicare, Covered Services will not exceed the Medicare approved expenses.

11.03 Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan

If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first eighteen (18) months of Medicare entitlement (with respect to charges Incurred on or after February 1, 1991 and before August 5, 1997), and for the first thirty (30) months of Medicare entitlement (with respect to charges Incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

ARTICLE XII
THIRD-PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

12.01 Payment Condition

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

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

3. In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

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

12.02 Subrogation

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

2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

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

4. If the Participant(s) fails to file a claim or pursue damages against:
    a. The responsible party, its insurer, or any other source on behalf of that party;

b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c. Any policy of insurance from any insurance company or guarantor of a third-party;
d. Workers' compensation or other liability insurance company; or
e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

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

12.03 Right of Reimbursement

1. The Plan shall be entitled to recover one hundred percent (100%) of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

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

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

12.04 Excess Insurance

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

The Plan's benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third-party;

4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

12.05 Separation of Funds

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

12.06 Wrongful Death

In the event that the Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third-party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

12.07 Obligations

1. It is the Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
    f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.

2. If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant(s)' cooperation or adherence to these terms.

12.08 Offset

If timely repayment is not made, or the Plan Participant and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) in an amount equivalent to any outstanding amounts owed by the Plan Participant to the Plan.

12.09 Minor Status

1. In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor’s parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor’s parents or court-appointed guardian.

12.10 Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan’s subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

12.11 Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ARTICLE XIII
MISCELLANEOUS PROVISIONS

13.01 Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA") and the laws of the State of Pennsylvania. The Plan is funded with Employee and/or Employer contributions. As such, Federal law and jurisdiction preempt State law and jurisdiction.

13.02 Clerical Error/Delay

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

13.03 Conformity With Applicable Laws

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated Maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to the requirements of ERISA, as it applies to Employee welfare plans, as well as any other applicable law.

13.04 Fraud

The following actions by any Participant, or a Participant's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Participant is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Participant of the Plan;
2. Attempting to file a claim for a Participant for services which were not rendered or Drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

13.05 Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

13.06 No Waiver or Estoppel

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

13.07 Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

13.08 Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Participant for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

13.09 Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

13.10 Right of Recovery

In accordance with 9.06C, the Recovery of Payments provision , whenever payments have been made by this Plan in a total amount, at any time, in excess of the Maximum Amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. See 9.06C, the Recovery of Payments provision for full details.

13.11 Statements

All statements made by the Company or by a Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

Any Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

13.12 Protection Against Creditors

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or

former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his/her Spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

13.13 Binding Arbitration

***Note**: You are enrolled in a plan provided by your Employer that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules and is not subject to mandatory binding arbitration. You may pursue voluntary binding arbitration after you have completed an appeal under ERISA. If you have any other dispute which does not involve an adverse benefit decision, this Binding Arbitration provision applies.*

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

13.14 Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Third-Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Third-Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed.

Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA.

ARTICLE XIV
SUMMARY OF BENEFITS

14.01 General Limits

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions. All coverage figures are after the Out-of-Pocket Deductible has been satisfied.

Failure to comply with Utilization Management will result in a higher cost to Participants. “Utilization Management” includes Hospital pre-admission certification, continued stay review, length of stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables Maximum benefits under the Plan.

14.01A Services that Require Pre-Certification

The following services will require Pre-Certification (or reimbursement from the Plan may be reduced):

1. All Inpatient Surgeries and Diagnoses in a facility of a Non-Contracting Provider;
2. Inpatient Hospitalization;
3. Transplant (organ and/or tissue) Surgery;
4. Home Health Services;
5. Home Infusion Therapy;
6. Durable Medical Equipment, rental greater than 2 months, or purchase in excess of $500 billed per date of service;
7. Rehabilitation Hospital;
8. Psychiatric Hospital; and
9. Skilled Nursing Facility stays.

Remember that although the Plan will automatically pre-authorize a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours for a cesarean delivery, it is important to have your Physician call to obtain Pre-Certification in case there is a need to have a longer stay.

The Plan contracts with the medical Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called “Network Providers.” Those who have not contracted with the Networks are referred to in this Plan as “Non-Network Providers.” This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Provider Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive Medical Care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:
    a. The Network Provider level of benefits is payable when a Participant receives Emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency;

2. If the charge billed by a Non-Network Provider for any covered service is higher than the Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts Assignment of Benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee;

3. To receive benefit consideration, Participants must submit claims for services provided by Non-Network Providers to the Third-Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves; and

4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

14.02 Balance-Billing

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance-billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance-billing is legal in many jurisdictions, and the Plan has no control over Non-Network Providers that engage in balance-billing practices.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance-billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance-billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for payment of Out-of-Pocket Maximums and may be billed these.

Please refer to Article XXI "**Consolidated Appropriations Act Of 2021 Notice - Your Rights and Protections Against Surprise Medical Bills"** for additional information.

14.03 Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other healthcare Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third-Party Administrator. The delivery of medical and other healthcare services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other healthcare Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

14.04 Contracting Provider Information

This Plan contains provisions under which a Participant may receive more benefits by using certain Providers. These Providers are individuals and entities that have contracted with the Plan to provide services to Participants at pre-negotiated rates. The Contracting Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Contracting Provider.

A current list of Contracting Providers is available, without charge, through the Third-Party Administrator's website (located at www.highmarkbcbs.com**Error! Hyperlink reference not valid.**). If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, contact the Human Resources Department. The Contracting Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Contracting Provider before receiving services.

14.05 Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Allowable Charges and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to an Allowable Charge, in accord with the terms of this Plan Document.

14.06 Summary of Medical Benefits

The following benefits are per Participant per Calendar Year:

Benefit	Hospital	Medical/Surgical	Major Medical
General Provisions			
Benefit Period(1)	Calendar Year		
Deductible (per benefit period) Individual Family	 None None	 None None	$150 $450 4th quarter deductible carryover credit does not apply
Plan Pays – payment based on the plan allowance	100%	100% after deductible	80% after deductible
Out-of-Pocket Limit (Once met, plan pays100% coinsurance for the rest of the benefit period) Individual	None	None	$400
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	$7,300 Medical; $1,800 RX $14,600 Medical; $3,600 RX		
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	not covered	not covered	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	not covered	not covered	80% after deductible
Specialist Office Visits & Virtual Visits	not covered	not covered	80% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Virtual Visit Originating Site Fee	not covered	not covered	80% after deductible
Urgent Care Center Visits	not covered	not covered	80% after deductible
Telemedicine Services (3)	not covered	not covered	80% after deductible
Preventive Care (3)			
Routine Adult Physical Exams	100%	100%	not covered
Adult Immunizations	100%	100%	not covered
Routine Gynecological Exams	100%	100%	not covered
Routine Pap Smear	100%	100%	not covered
Mammograms, Annual Routine	100%	100%	not covered
Mammograms, Medically Necessary	100%	100%	not covered
Diagnostic Services and Procedures	100%	100%	not covered
Routine Pediatric Physical Exams	100%	100%	not covered
Pediatric Immunizations	100%	100%	not covered
Diagnostic Services and Procedures	100%	100%	not covered
Emergency Services			
Emergency Accident	100%	100%	not covered
Emergency Medical	100%	100%	not covered
Ambulance (4)	not covered	not covered	80% after deductible
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	100% after $5 copay for day for the first 15 days	100%	not covered
Hospital Outpatient	100%	not covered	not covered
Maternity (non-preventive facility & professional services)	100% after $5 copay for day for the first 15 days	100%	not covered
Maternity for Dependent Daughters	100%	100%	not covered
Medical Care (including inpatient visits and consultations) / Surgical Expenses	not covered	100%	not covered
Therapy and Rehabilitation Services			
Physical Medicine	100%	not covered	80% after deductible
Respiratory Therapy	100% Covered during the 90 day period following an Inpatient stay.	not covered	not covered
Speech Therapy	not covered	not covered	80% after deductible
Occupational Therapy	not covered	not covered	80% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Spinal Manipulations	not covered	not covered	80% after deductible
Cardiac Rehabilitation Therapy	100%	not covered	not covered
Infusion Therapy	100%	not covered	not covered
Chemotherapy	100%	100%	not covered
Nutritional Therapy	not covered	not covered	80% after deductible. benefit maximum of 6 visits, per member, per benefit period. not subject to deductible
Radiation Therapy	100%	100%	not covered
Dialysis	100%	100%	not covered
Mental Health / Substance Abuse			
Inpatient Mental Health Services	100% after $5 copay for day for the first 15 days	100%	not covered
Inpatient Substance Abuse Detoxification	100% after $5 copay for day for the first 15 days	100%	not covered
Inpatient Substance Abuse Rehabilitation	100%	100%	not covered
Outpatient Mental Health Services (includes virtual behavioral health visits)	not covered	not covered	100% (deductible does not apply)
Outpatient Substance Abuse Services	100%	100%	not covered
Other Services			
Allergy Extracts	not covered	100%	not covered
Allergy Injections	not covered	100%	not covered
Applied Behavior Analysis for Autism Spectrum Disorder (5)	100%	100%	80% after deductible
Assisted Fertilization Procedures	not covered	not covered	not covered
Dental Services Related to Accidental Injury	100%	100%	80% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	100%	not covered
Outpatient Diagnostic Services	100%	100%	not covered
Standard Imaging	100%	100%	not covered
Diagnostic Medical	100%	100%	not covered
Pathology/Laboratory	100%	100%	not covered
Allergy Testing	100%	100%	not covered

Benefit	Hospital	Medical/Surgical	Major Medical
Durable Medical Equipment Orthotics and Prosthetics (includes coverage for Ostomy supplies)	not covered	not covered	80% after deductible
Home Health Care	100% benefit maximum of 100 visits, per benefit period aggregate with visiting nurse	not covered	not covered
Hospice	100% benefit maximum of 180 days, per lifetime	not covered	not covered
Infertility	100% Testing to determine Infertility only	100% Testing to determine Infertility only	not covered
Private Duty Nursing	not covered	not covered	80% after deductible benefit maximum of 240 hours, per benefit period
Skilled Nursing Facility Care	100% after $5 copay for day for the first 15 days	100%	not covered
Transplant Services	100%	100%	not covered
Precertification Requirements (6)	Yes	No	No
Prescription Drugs			
Prescription Drug Deductible Individual Family	 none none		
Prescription Drug Program (7) Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30-day Supply)** $10 Formulary generic copay $10 Non-Formulary generic copay $20 Formulary brand copay $35 Non-Formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $10 Formulary generic copay $10 Non-Formulary generic copay $40 Formulary brand copay $70 Non-Formulary brand copay		

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Services are limited to those listed on the Highmark Preventive Schedule with enhancements (Women's Health Preventive Schedule may apply).
(4) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits.
(5) Coverage for eligible members to age 21. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy).
(6) Be sure your provider is aware that Highmark Utilization Management must be contacted for authorization prior to a planned inpatient admission or within 48 hours of an emergency or unplanned inpatient admission. Also note that certain outpatient procedures require prior authorization. If authorization is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate you will be responsible for the payment of any costs not covered by your health plan.
(7) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Your plan requires that you use Accredo specialty pharmacy to obtain select specialty medications.

ARTICLE XV
MEDICAL BENEFITS

Subject to the exclusions, conditions and limitations of the Plan, a Participant is entitled to covered services described in the Plan and is responsible for the Deductible, Copayment and Coinsurance, if any, as specified herein and in the Summary of Benefits. The Summary of Benefits specifies the Benefit Period selected by the Plan.

For services, which are not provided by a Contracting Provider, the Participant will be responsible for the application of a higher Coinsurance level as described in the Summary of Benefits. A charge for a covered service shall be considered Incurred on the date the service or supply was provided to a Participant.

15.01 Definitions

Coinsurance - Payment will be made in each Benefit Period on behalf of a Participant for the percentage of the Allowable Charge for Covered Medical Services as specified below and as included in the Summary of Benefits:

1. For covered services rendered by Contracting Providers, the Plan will pay one hundred percent (100%) of the Allowable Charge in each Benefit Period on behalf of the Participant, unless otherwise indicated in the Summary of Benefits, by which the Allowable Charge exceeds any Deductible amounts. The Summary of Benefits specifies the Deductible amounts, if any, that apply to professional covered services;

2. For covered services rendered by Non-Contracting Providers, the Plan will pay seventy percent (70%) of the Allowable Charge in each Benefit Period on behalf of the Participant, by which the Allowable Charge exceeds any Deductible amounts. The Summary of Benefits specifies the Deductible amounts, if any, that applies to professional covered services.

   The Participant is responsible for thirty percent (30%) of the Allowable Charge. The Participant is also responsible for the difference between the Plan's payment and the Provider's billed charge unless otherwise indicated in the Summary of Benefits. Covered services provided by a Non-Contracting Provider for Outpatient Emergency Accident services and Outpatient medical Emergency Services are payable at a rate at which the Participant will not incur a greater Out-Of-Pocket expense than would have been Incurred had the Participant been able to choose a Contracting Provider;

3. For major medical covered services, payment will be made in each Benefit Period on behalf of a Participant for the percentage of the amount, as specified in the Summary of Benefits, by which the Allowable Charges exceed the major medical Deductible. The Summary of Benefits specifies the Deductible amounts that apply to major medical covered services; and

4. The eligible covered services under major medical are as follows:

   i. Physician office visits;
   ii. Outpatient Physical, Speech, Occupational Therapies;
   iii. Nutritional Therapy;
   iv. Outpatient mental health care services;
   v. Chiropractic covered services; ND
   vi. Durable Medical Equipment/Prostheses/Orthoses/Ostomy Supplies.

Coinsurance Maximum - Coinsurance Maximum applies to major medical covered services. When a Participant incurs the amount of Coinsurance expense as specified in the Summary of Benefits in a Benefit Period for major medical covered services, the Coinsurance percentage will be reduced to zero percent (0%) for the balance of that Benefit Period, unless otherwise indicated in the Summary of Benefits.

Copayment - The amount, if any, a Participant must pay directly to Providers in connection with covered services set forth in the Summary of Benefits.

Cross Product Accumulation - If a Participant changes products offered by Highmark Blue Cross Blue Shield while with the same Plan during a Benefit Period, or if a Participant changes Deductibles during a Benefit Period while with the same Plan, eligible expenses, which were applied to the original Deductible and Coinsurance Maximum, will be eligible for credit towards the new Deductible and Coinsurance Maximum amounts during the remainder of that same Benefit Period.

Deductible - When a Deductible applies, it applies per Participant per Benefit Period or as indicated in the Summary of Benefits to all major medical Covered Services and a separate Deductible applies to Professional Provider Covered Services. The Deductible also does not apply to the following services provided for in the Affordable Care Act or as indicated in the Summary of Benefits when billed as preventive in nature: pediatric preventive exams and screenings, adult preventive screenings and preventive Drugs. The Summary of Benefits specifies the Deductible amounts that apply to major medical Covered Services and to Covered Services of Professional Providers.

For major medical Covered Services, the eligible Deductible amounts, which are Incurred by the three (3) separate family members covered under the Plan, may be contributed to the family Deductible, which is three (3) times the amount for an individual in any one Benefit Period. No one family member's Deductible expense may exceed the individual Deductible. Deductible and Coinsurance amounts for family members that did not satisfy the individual limits will not be refunded in the event the family Deductible or family Coinsurance Maximum is met by the specified number of separate family members. The Summary of Benefits specifies the Deductible that applies to major medical Covered Services.

Medical Lifetime Benefit Maximum - Is unlimited per lifetime, per Participant.

15.02 Care Coordination

15.02A Selection of Providers

A Participant covered under the Plan has the option of choosing where and to whom to go for covered services.

Covered services may be rendered by a Contracting Provider, a Non-Preferred Contracting Provider, or a Non-Contracting Provider.

15.02B Emergency Services

In the event that the Participant requires Emergency Service, the Plan will provide coverage at the Contracting Provider level and the Participant's Out-Of-Pocket expense will be no greater than the amount that would have been Incurred if the Participant had been able to choose a Contracting Provider. For Inpatient Emergency admissions to a Non-Contracting Provider, the Participant is responsible for notifying the Plan or its designated agent within forty-eight (48) hours of the Emergency Service or as soon as reasonably possible. Once an Insured is stabilized, to continue coverage at the higher reimbursement level, the Plan reserves the right to transfer the Participant's care from a Non-Contracting Provider to a Contracting Provider.

15.02C Medically Necessary Services

Medical Necessity for covered services will be initially determined prior to the service being rendered when Pre-Certification is required. When Pre-Certification is not required, the Plan may determine that a service was not Medically Necessary after service has been rendered. The Plan only covers services that it determines to be Medically Necessary. The Participant should be aware that services may be denied for lack of Medical Necessity after the service has been rendered. Therefore, if a Participant has a concern about a service requiring Pre-Certification, he/she should contact the Pre-Certification Department of the Third-Party Administrator prior to the service being rendered.

Based upon the evidence as required, the Third-Party Administrator shall determine the Medical Necessity for covered services. However, the Participant shall have the right to appeal such determinations as set forth in the Plan.

15.03 Medical Benefits

Subject to the exclusions, conditions and limitations of the Plan, a Participant is entitled to covered services described in the Plan, in accordance with the Deductible, Copayment and Coinsurance, if any, and in the amounts as specified herein and in the Summary of Benefits. The Summary of Benefits also specifies the Benefit Period selected by the Plan.

The Participant is always responsible for Copayments, Deductibles and Coinsurance in the amounts shown for covered services as included herein, in the Summary of Benefits that accompanies the Plan.

Pre-Certification requirements must be followed as discussed in the Cost Containment section. Inpatient Emergency admissions must be reviewed within forty-eight (48) hours of the admission, or as soon as reasonably possible. A concurrent review is required for any continued length of stay beyond what has been Pre-Certified by the Plan.

The Traditional Plan shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)) beginning on or after March 15, 2020:

(1) In vitro diagnostic products (as defined in section 809.3(a) of title 21, Code of Federal Regulations) for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized under section 510(k), 513, 515 or 564 of the Federal Food, Drug, and Cosmetic Act, and the administration of such in vitro diagnostic products.
(2) Items and services furnished to an individual during health care provider office visits (which term in this paragraph includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (1), but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product.

A diagnostic product will include any test:

(1) Approved by the United States Food and Drug Administration (“FDA”);
(2) For which the developer has requested (or will request) emergency use authorization from the FDA;
(3) Developed in and authorized by a state that has notified the Secretary of Health and Human Services (“HHS”) that it intends to review tests intended to diagnose COVID-19; and
(4) The Secretary of HHS determines to be appropriate.

Additionally, the Traditional Plan will provide cost-free coverage of any qualifying coronavirus preventive service within 15 business days after the date on which a recommendation is made with respect to the qualifying coronavirus preventive service., which is defined as including any item, service or immunization intended to prevent or mitigate COVID-19 and that is either:

(1) An evidence-based item or service with an "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force or
(2) An immunization with a recommendation from the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

1. **Allergy Extracts/Injections**
   Covered services are provided for allergy extracts and antigen injections.

2. **Ambulance Services**
   Covered services are payable for Medically Necessary ambulance services by land, air or water, Advanced Life Support (ALS) or Basic Life Support (BLS) for local transportation. The ambulance must be transporting the Participant:

   a. From home or from the scene of an Accident or Medical Emergency to the nearest Hospital;
   b. Between Hospitals;
   c. Between a Hospital and Skilled Nursing Facility;
   d. From a Hospital or Skilled Nursing Facility to the Participant's home;
   e. From the Participant's home or from a Facility Provider to an Outpatient treatment site; or
   f. From an Outpatient treatment site to the nearest Hospital.

   If there is no facility in the local area that can provide covered services for the Participant's condition, then ambulance service means transportation to the closest facility outside the local area that can provide the necessary service. If the Participant chooses to go to another facility that is farther away, payment will be based on the Allowable Charge for transportation to the closest facility that can provide the necessary services.

3. **Ancillary Services**
   Covered services are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items), including, but not limited to the following:

   a. Meals, including special meals or dietary services as required by the patient's condition;
   b. Use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
   c. Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body, except when considered Experimental or Investigative by the Plan;
   d. Oxygen and oxygen therapy;
   e. Administration of blood and blood plasma, including the processing of blood from donors, but excluding the blood or blood plasma, except as provided under the Blood and Blood Plasma section;
   f. Anesthesia and the supplies and use of anesthetic equipment;
   g. Diagnostic Services;
   h. Therapy Services;
   i. Inpatient rehabilitation therapy limited to as indicated in the Summary of Benefits;
   j. All FDA-approved Drugs (including intravenous solutions), cancer Chemotherapy and cancer hormone treatment for use while in the Hospital;
   k. Use of special care units, including, but not limited to, intensive or coronary care; and
   l. Pre-admission testing and studies required in connection with the Participant's admission rendered or accepted by a Provider on an Outpatient basis prior to a scheduled admission to a Hospital or Facility Provider. Pre-admission testing does not include tests or studies performed to establish a Diagnosis. Covered services for Pre-Admission Testing will not be provided if the Participants cancel or postpone the admission. If the Provider or Physician cancels or postpones the admission, covered services will be provided.

   Covered services are payable for ancillary services provided for and billed for by the Hospital for an Inpatient admission resulting from an Accident or Emergency Medical Condition

4. **Anesthesia**

Administration of general anesthesia in a Hospital or Ambulatory Surgical Facility when in connection with the performance of covered services and when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Professional Provider is covered.

Coverage for general anesthesia in connection with the extraction of partially or totally bony impacted wisdom teeth is described in the Surgery section.

Hospitalization and all related medical expenses normally Incurred as a result of the administration of general anesthesia in a Hospital or Ambulatory Surgical Facility in connection with the performance of non-covered dental procedures or non-covered oral Surgery, are covered when determined by the Plan to be Medically Necessary for the following Participants when a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected under general anesthesia:

a. Children under the age of eighteen (18);
b. Adults who are developmentally disabled;
c. Participants with complex medical conditions, when performing the Surgery/procedure in any setting other than a Hospital or Ambulatory Surgical Facility would present an unacceptable risk to the patient's health; or
d. When one of the following is present:
    i. It is a required part of a broader treatment plan requiring radiation of the head and/or neck;
    ii. There is non-dental diseases eroding or invading the maxilla and/or mandible, the treatment of which necessitated removal of the Insured Person's teeth;
    iii. There is infection of the teeth and gums that places the Insured Person's health at risk if uncorrected prior to other Medically Necessary treatment such as but not limited to Chemotherapy or transplant; or
    iv. Local anesthesia and conscious sedation are covered regardless of setting.

5. Blood and Blood Plasma

Covered services will be provided for whole blood, blood plasma, the administration of blood and blood processing, and blood derivatives, which are not classified as Drugs by the U.S Food and Drug Administration ("FDA").

6. Chiropractic Manipulative Covered Services

Chiropractic Manipulative Treatments, consultations, and Adjunctive Procedures are limited to a combined Maximum per Benefit Period as set forth in the Summary of Benefits, if Medically Necessary.

7. Concurrent Care

8. Services rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Participant, standby services, routine pre-operative physical examinations or Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods or Medical Care required by a Facility Provider's rules and regulations.

9. Consultations

Consultation services when rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider at the request of the attending Professional Provider. Consultations do not include staff consultations, which are required by Facility Provider's rules and regulations.

Covered services are limited to one (1) consultation per consultant during any Inpatient confinement.

10. Diabetes Education/Equipment/Supplies

a. <u>Diabetes Education</u>

Covered services are provided for diabetes education services as described herein or as indicated in the Summary of Benefits. Diabetes Outpatient self-management training and education shall be provided under the supervision of a licensed health care professional with expertise in diabetes to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. Coverage for self-management education and education relating to diet and prescribed by a licensed Physician shall include: (1) visits Medically Necessary upon the Diagnosis of diabetes; (2) visits under circumstances whereby a Physician identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management; and (3) where a new medication or therapeutic process relating to the person's treatment and/or management of diabetes has been identified as Medically Necessary by a licensed Physician.

b. Diabetic Equipment and Supplies

Equipment and supplies for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes when prescribed by a health care professional legally authorized to prescribe such items or as indicated in the Summary of Benefits. Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and Orthoses. Equipment and supplies prescribed as a result of diabetes as set forth in this subsection are not subject to the Maximum included in Durable Medical Equipment/Prostheses/Orthoses/Ostomy Supplies section.

Equipment and supplies must be prescribed by a licensed Provider and are subject to applicable Deductibles and Coinsurance. Equipment and supplies prescribed as a result of diabetes as set forth in this subsection are not subject to the Maximum included in Durable Medical Equipment/Prostheses/Orthoses/Ostomy Supplies sections.

11. Diagnostic Services--Outpatient

Covered services are provided for the following Diagnostic Services when ordered by a Professional Provider and billed by a Professional Provider, independent clinical laboratory, and/or a Facility Provider:

a. Diagnostic radiology, consisting of x-ray, ultrasound and nuclear medicine;
b. Diagnostic mammograms, including digital breast tomosynthesis ("3D mammography") which are recommended by a Physician, are covered for all Participants. Diagnostic mammograms performed by a Participating Provider are exempt from all Deductibles and Maximums;
c. Diagnostic laboratory and pathology tests;
d. Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other diagnostic medical procedures approved by the Plan;
e. Diagnostic imaging procedures consisting of Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computed Tomography (CT) scan, Computed Tomography Angiography (CTA) scan, Positron Emission Tomography (PET) scan, Single Photon Emission Computerized Tomography (SPECT), and nuclear cardiology studies approved by the Plan. The Participant may be responsible for a copayment as indicated in the Summary of Benefits.
   If the diagnostic imaging procedure is rendered in conjunction with an Outpatient emergency room visit, Inpatient admission, observation status, or ambulatory Surgical Procedure, the Copayment per test/scan will be waived; or
f. Allergy testing consisting of percutaneous, intracutaneous and patch tests.

12. Durable Medical Equipment/Prostheses/Orthoses

Covered services are provided for Durable Medical Equipment, prostheses, and orthoses when prescribed by a licensed health care professional. Except for initial and subsequent prosthetic devices to replace the removed breast or portion thereof, replacements of Durable Medical Equipment, Prostheses and Orthoses are not included, other than as certified as Medically Necessary for Children due to the normal growth process.

Instructions regarding appropriate use of the item are covered.

Covered Durable Medical Equipment includes, but is not limited to, the following:

a. Hospital beds and related equipment (bed rails, mattresses);
b. Equipment to increase mobility (walkers, wheelchairs);
c. Commodes (elevated seats, portable bedside commodes);
d. Breathing apparatus (positive and intermittent positive pressure breathing machines, suction machines);
e. Therapeutic equipment;
f. Apnea monitors;
g. Jobst pressure garments used in burn treatment; and
h. Unna boots and air casts.

Covered Prostheses and Orthoses include, but are not limited to, the following:

a. Artificial limbs;
b. Knee braces, not made of elastic or fabric support;
c. Splints (acrimo-clavicular or zimmer, carpal tunnel, clavicle or "figure-8", finger, Pavlik harness and wrist);
d. Immobilizers;
e. Corrective shoes, shoe inserts and supports, and/or other foot Orthoses;
f. Supportive back braces with metal stays;
g. Dynasplints; and
h. Cryocuffs.

Covered services are not payable for dental appliances, wigs, or eyeglasses, except as specified in the Surgery section.

13. Emergency Care Covered Services

Emergency care covered services include treatment and services provided in the Outpatient department of a Hospital for an Emergency Medical Condition.

a. Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for Emergency treatment of bodily Injury resulting from an Accident shall be covered;
b. Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for Emergency treatment of a medical condition with acute symptoms, which would result in requiring immediate Medical Care, shall be covered;
c. If Accident services are classified as Surgery (e.g., suturing, fracture care, etc.), payment to a Professional Provider will be made as a surgical covered service; and
d. Visits which are performed in the Outpatient department of a Hospital that are follow-up to Emergency Accident care and Emergency Medical Care are classified and payable as Outpatient covered services.

14. Experimental or Investigational Services

The Plan shall determine whether the use of any treatment, procedure, Provider equipment, Drug, device, or supply (each of which is hereafter called a "Service") is Experimental or Investigational (that is not supported by evidence-based medicine). Services or treatments that are the subject of, or in some manner related to, the conduct of an Approved Clinical Trial are not considered Experimental or Investigational.

a. If, in making that determination, the Plan finds that the service, for which a claim for covered services is made, is either, (1) the subject of a written Investigational or research protocol used by the treating Provider or of a written Investigational or research protocol of another Provider studying substantially

the same service; or (2) the subject of a written informed consent used by the treating Provider which refers to the service as Experimental, Investigative, educational, or research; or (3) the subject of an on-going phase I or II clinical trial, the service shall be deemed to be Experimental or Investigative;

b. If, in making that determination, the Plan finds that neither a protocol, an informed consent, nor an on-going clinical trial, as described above, exist, then the Plan may require that demonstrated evidence exists, as reflected in the published Peer Reviewed Medical Literature that:
    i. The technology must have final approval from the appropriate governmental regulatory bodies;
    ii. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
    iii. The technology must improve the net health outcome;
    iv. The technology must be as beneficial as any established alternatives; and
    v. The improvement must be attainable outside the Investigational settings.

    Peer Review Medical Literature means two (2) or more U.S. scientific publications which require that manuscripts be submitted to acknowledge experts inside or outside the editorial office in their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as Peer Reviewed Medical Literature, the manuscript must actually have been reviewed by acknowledged experts before publications; and

c. If, in making the determination, the Plan finds that a Drug, a device, a supply, or equipment has not received marketing approval (permission for commercial distribution) by the United States Food and Drug Administration: (1) at the time the service is received; and (2) for the purpose for which it is rendered; and (3) for the manner in which it is rendered, the Drug, device, supply, or equipment shall be deemed to be Experimental or Investigational.

15. Home Health Care

Subject to the following provision, covered services will be provided for unlimited Home Health Care visits per Benefit Period or as indicated in the Summary of Benefits.

Covered services will be provided for the following when performed by a licensed Home Health Care Agency:

a. Professional services of a Registered Nurse or Licensed Practical Nurse, but not including private duty nurses;
b. Home health aide services as assigned and supervised by a Registered Nurse or Licensed Practical Nurse;
c. Physical Therapy treatments performed by a licensed Physical Therapist;
d. Speech Therapy services when provided by a licensed Speech Therapist holding a Certificate of Clinical Competency;
e. Occupational Therapy treatments when provided by or supervised by a licensed Occupational Therapist;
f. Medical social service consultations when provided by a qualified medical social service worker holding a master's degree in social work;
g. Nutritional Therapy provided by a Licensed Dietitian[3];
h. Diagnostic and therapeutic radiology services;
i. Laboratory services;
j. Medical diagnostic tests and studies;
k. Oxygen and Respiratory Therapy;

[3] Nutritional Therapy provided to a Homebound Participant will not reduce the covered service provided under Medical Benefits section of the Plan.

l. Medical and surgical supplies, including bandages, Ostomy Supplies, dressings and casts; and
m. The rental of Durable Medical Equipment but only on a short term basis and if not owned by the Home Health Care Agency.

When a discharge occurs within forty-eight (48) hours following a Hospital admission for a Mastectomy, covered services will be provided for one (1) Home Health Care visit within forty-eight (48) hours of the Hospital discharge. Pre-Certification will not be required for this visit.

Covered services will be provided only for services if (a) the services are prescribed by the Participant's attending Physician, (b) the Participant received Pre-Certification approval from the Plan as set forth in the Cost Containment section, and (c) the Participant's Physician has furnished, in consultation with the Home Health Care Agency's professional personnel prior to the first visit, a plan of treatment stating that the services are Medically Necessary. Continuing eligibility requires that the attending Physician provide such a plan of treatment at intervals of no less than every thirty (30) days.

When a discharge occurs within forty-eight (48) hours following a Hospital admission for a normal vaginal delivery or within ninety-six (96) hours following a Hospital admission for cesarean delivery, covered services will be available for one (1) home health care visit within forty-eight (48) hours of the Hospital discharge. Pre-Certification will not be required for this visit.

At the discretion of the mother, a visit may occur at home or at the facility of the Provider. It is necessary to use a Provider included in the Plan's Network of contracted Providers in order to avoid a covered service reduction of the eligible charges, except for Emergency Care or when covered services are not available from a Contracting Provider. Postpartum Home Health Care visits are exempt from any Copayment, Coinsurance or Deductible amounts.

No Home Health Care covered services will be provided for:

a. Food or home delivered meals;
b. Professional Medical Services billed by a Physician;
c. Custodial Care;
d. Services of a housekeeper;
e. Private Duty Nursing;
f. Ambulance service;
g. Drugs, including Prescription Drugs; and
h. Services provided by Immediate Family or members of the Participant's household.

16. Home Infusion Therapy

Covered services will be provided for the following services provided to a Participant by a Home Infusion Therapy Agency:

a. Total parenteral nutrition*;
b. Enteral nutrition*;
c. Intravenous therapy;
d. Cancer Chemotherapy and cancer hormone treatment;
e. Anti-infective therapy (*Lyme Disease);
f. Pain management (continuous and epidural analgesics); and
g. Immune globulin therapy*.

The Home Infusion Therapy Agency shall supply all items used directly with Home Infusion Therapy to achieve therapeutic benefits and to assure proper functioning of the system, including, but not limited to: catheters, concentrated nutrients, dressings, enteral nutrition preparation, extension tubing, filters, heparin sodium

(parenteral only), infusion bottles, IV pole, liquid diet (for catheter administration), needles, pumps, tape and volumetric monitors.

All therapies are subject to prospective, concurrent and/or retrospective utilization review by health care professionals, and further may require Pre-Certification to determine if a therapy is Medically Necessary and appropriate. Before delivering the therapy, a preferred Home Infusion Therapy Agency will advise the Participant if Pre-Certification is required

*Therapies that generally require Pre-Certification or are noted with an asterisk above. Any therapy or Drug, the use of which is not FDA approved may be considered Experimental/Investigative and, therefore, must be Pre-Certified or pre-approved. Pre-Certification procedures apply as set forth in the Cost Containment section.

Home Infusion Therapy covered services will not be provided for:

a. Participants who are receiving covered services under the Hospice Care program;
b. Blood and blood products therapy; and
c. Any injectable Drugs covered under any other covered services section of the Plan.

16. Hospice Care

When the Participant's attending Physician certifies to the Plan that the Participant has a terminal Illness with a life expectancy of six (6) months or less and when the Participant elects to receive care primarily in the home to relieve pain and to enable the Participant to remain at home rather than to receive other types of care, the Participant shall be eligible for Hospice Care covered services.

Covered services for Hospice Care shall be provided as indicated in the Summary of Benefits. These covered services are in addition to, and not in lieu of, any other covered services in the Plan. If the Participant or the Participant's responsible party elects to institute curative treatment to sustain life, the Participant will not be eligible to receive further Hospice Care covered services until the cessation of such curative treatment.

The Hospice Care covered service will include coverage for continuous care consisting of nursing care for up to twenty-four (24) hours per day necessary to maintain the patient at home or acute Inpatient care for a period of crisis when Medically Necessary and not solely for comfort measures. A Maximum, as indicated in the Summary of Benefits, is available for continuous and/or Inpatient care. Respite Care on a short-term Inpatient basis in a Hospital or Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the patient’s home. Respite Care is available with a Maximum as indicated in the Summary of Benefits. Covered services are payable according to the Maximums set forth in herein.

Covered services will be provided for supportive services at each level of care to a terminally ill Participant by a Hospice Care program in accordance with a treatment plan approved by and periodically reviewed by the Network. The following services provided to a Participant by an approved Hospice responsible for the patient's overall care will be eligible for coverage:

a. Professional services of a Registered Nurse or Licensed Practical Nurse;
b. Pain management;
c. Chemotherapy and/or Radiation Therapy;
d. Parenteral or enteral nutrition therapy;
e. Prescription Drugs;
f. Laboratory services;
g. Dietitian services;

h. Medical and surgical supplies, Ostomy Supplies, and Durable Medical Equipment[4];
i. Oxygen and its administration;
j. Medical social service consultation provided by a social worker;
k. Counseling services provided to the Participant and/or family members related to the patient's terminal condition, including bereavement counseling;
l. Home health aide and homemaker services; and
m. Any needed therapies.

17. Hospital Services

a. Room and Board

i. Covered services are payable for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:

(1) A Semi-Private Room, as designated by the Hospital; or a private room, when designated by the Network as semi-private for the purposes of the Plan, in Hospitals having primarily private rooms;
(2) A private room. The private room allowance is the Semi-Private Room charge;
(3) A special care unit, such as intensive or coronary care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;
(4) A bed in a general ward; and
(5) Nursery facilities.

Covered services are payable for a length of stay following a Mastectomy that a treating Physician determines is necessary to meet generally accepted criteria for safe discharge.

Covered services are payable for Hospital services for an Inpatient admission resulting from an Accident or Emergency Medical Condition that a treating Physician determines is Medically Necessary. Covered services are provided for an unlimited number of days per Benefit Period.

In computing the number of days of covered services, the day of admission, but not the date of discharge, shall be counted. If the Participant is admitted and discharged on the same day, it shall be counted as one day.

Days available under the Plan shall be allowed only during uninterrupted stays in a Hospital. Covered services shall not be provided: (1) for any day during which a Participant interrupts his/her stay; or (2) after the discharge hour that the Participant's attending Physician has recommended that further Inpatient care is not required.

b. Ancillary Services

Covered services are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items), including, but not limited to the following:

i. Meals, including special meals or dietary services as required by the patient's condition;
ii. Use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
iii. Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body, except when considered Experimental or Investigative by the Plan;
iv. Oxygen and oxygen therapy;

[4] Ostomy Supplies provided to a Participant as part of Hospice Care will not reduce the covered services provided under Ostomy Supplies of the Medical Benefits section of the Plan.

v. Administration of blood and blood plasma, including the processing of blood from donors, but excluding the blood or blood plasma, except as provided under Blood and Blood Plasma in this section;
vi. Anesthesia and the supplies and use of anesthetic equipment;
vii. Diagnostic Services;
viii. Therapy Services;
ix. Inpatient rehabilitation therapy limited as the Summary of Benefits indicates;
x. All FDA-approved Drugs (including intravenous solutions), cancer Chemotherapy and cancer hormone treatment for use while in the Hospital;
xi. Use of special care units, including, but not limited to, intensive or coronary care; and
xii. Pre-admission testing and studies required in connection with the Participant's admission rendered or accepted by a Provider on an Outpatient basis prior to a scheduled admission to a Hospital or Facility Provider. Pre-admission testing does not include tests or studies performed to establish a Diagnosis. Covered services for Pre-Admission Testing will not be provided if the Participant cancels or postpones the admission. If the Provider or Physician cancels or postpones the admission, covered services will be provided.

Covered services are payable for ancillary services provided for and billed for by the Hospital for an Inpatient admission resulting from an Accident or Emergency Medical Condition.

18. Maternity Services

Services rendered in the care and management of a Pregnancy for a Participant are covered services under the Plan. Covered services are payable for:

a. Normal Pregnancy

Normal Pregnancy includes any condition usually associated with the management of a difficult Pregnancy, but not considered a complication of Pregnancy;

b. Complications of Pregnancy

Physical effects directly caused by Pregnancy, but which were not considered from a medical viewpoint to be the effect of normal Pregnancy, including conditions related to ectopic Pregnancy or those that require cesarean section;

c. Minimum Length of Stay

Coverage will be provided for a minimum of forty-eight (48) hours of Inpatient care following normal vaginal delivery and ninety-six (96) hours of care following cesarean delivery. A shorter length of stay may be justified when the treating or attending Physician determines in consultation with the mother that she and the newborn meet medical criteria for safe discharge in accordance with guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Those guidelines determine appropriate length of stay based upon, but not limited to, the following: the evaluation of the antepartum, intrapartum and postpartum course of the mother and infant; the gestational stage, birth weight and clinical condition of the infant; the demonstrated ability of the mother to care for the infant post-discharge; and the availability of the post-discharge follow-up care to verify the condition of the infant and mother within forty-eight (48) hours after discharge.

When a discharge occurs within forty-eight (48) hours following a Hospital admission for a normal vaginal delivery or within ninety-six (96) hours following a Hospital admission for cesarean delivery, covered services will be available for one (1) Home Health Care visit within forty-eight (48) hours of the Hospital discharge. At the discretion of the mother, a visit may occur at home or at the facility of the Provider. Home health care visits shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical

assessments. The postpartum home health visit is exempt from any Deductibles, Copayments or Coinsurance;

d. Interruptions of Pregnancy
   i. Miscarriage; and
   ii. Medical procedures which are necessary to avert the death of a woman; and
   iii. Coverage for illness or injury caused by complications from any abortion.

e. Nursery Care
   Ordinary nursery care of the newborn infant;

f. Routine Newborn Care
   The newborn Child of any covered Participant, Spouse, or Dependent shall be entitled to covered services provided by the Plan from the date of birth up to a Maximum of thirty-one (31) days. Such coverage within the thirty-one (31) days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, pre-maturity and routine nursery care.

   Routine neonatal circumcision is not covered;

19. Mental Health Care Services

a. Covered services for the treatment of Mental or Nervous Disorders and for the treatment of Serious Mental Illness are based on the services provided and reported by the Provider. Those services provided by and reported by the Provider as mental health care are subject to the mental health care limitations in the Plan. When a Provider renders Medical Care, other than mental health care, for a Participant with Serious Mental Illness or with a Mental or Nervous Disorder, payment for such Medical Care will be based on the medical covered services available and will not be subject to the mental health care limitations in the Plan;

b. Except in an Emergency, Inpatient and Partial Hospitalization covered services are provided when Medically Necessary and when PerformCare is notified by the Provider or the Participant before the covered services are rendered and PerformCare coordinates the Participant's care prior to Covered Services being rendered;

c. Inpatient Services

   i. Inpatient Services will be provided for admissions for Serious Mental Illness and Mental or Nervous Disorders in an Inpatient Mental Health Hospital. Pre-Certification requirements must be followed as discussed in the Cost Containment section. A concurrent review is required for any continued length of stay beyond what has been pre-certified by PerformCare;

d. Outpatient Services

   i. Outpatient services will be provided during a Benefit Period for Mental or Nervous Disorders and for Serious Mental Illness; and
   ii. Outpatient mental health care services include Outpatient professional visits and Outpatient Partial Hospitalization days;

20. Metabolic Formulas

Metabolic Formulas only for the therapeutic treatment of phenylketonuria (PKU), branched chain ketonuria, galactosemia and homocystinuria. This covered service does not include coverage for normal food products used in the dietary management of rare genetic metabolic disorders;

21. Observation Status

Services furnished on a Hospital's premises include use of a bed and periodic monitoring by Hospital's nursing or other staff, which are reasonable and necessary to evaluate an Outpatient's condition or determine the need for a possible admission to the Hospital as an Inpatient;

22. Ostomy Supplies

Covered Ostomy Supplies include and are limited to the following:

a. Ostomy appliances and supplies specifically relating to an Ostomy (colostomy, ileostomy, urostomy or tracheostomy) are limited to collection devices, irrigation equipment and supplies, skin barriers and skin protectors;
b. Urinary catheters, both reusable or disposable, whether or not used in conjunction with an Ostomy; and
c. Ostomy Supplies are covered up to a Maximum as indicated in the Summary of Benefits. Coverage is limited to supplies obtained from Contracting Providers.

23. Oxygen and Related Equipment/Supplies

Oxygen and related equipment and supplies for use in the patient's home are covered;

24. Physician Office Visits

Covered services are provided for Medical Care, visits and consultations rendered and billed by a Professional Provider to a Participant who is an Outpatient. Covered services are provided for the examination, Diagnosis, and treatment of an Illness or Injury and routine office visits. Adult care includes routine physical examinations, regardless of their Medical Necessity, including a complete medical history plus necessary Diagnostic Services. With the exception of visits and consultations for Chiropractic Manipulative Treatment, there is an unlimited visit Maximum per Benefit Period. For Chiropractic Manipulative Treatment, the Participant is subject to the combined Maximum included in the Summary of Benefits;

25. ACA Preventive Care

Coverage will be provided for the preventive care services provided for in the Affordable Care Act and Health Resources and Services Administration's (HRSA) Women's Preventive Services: Required Health Plan Coverage Guidelines. The frequency and eligibility of services are subject to change to conform to the guidelines and recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Center for Disease Control, and the Health Resources and Services Administration. Preventive care services include, but are not limited to the following:

a. <u>Immunizations</u>
   i. Coverage will be provided for those pediatric immunizations, including immunizing agents, which, as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services. Pediatric immunizations are available until the Participant attains age twenty-one (21). Pediatric immunizations which are provided by a Contracting Provider are exempt from Deductibles, Copayments, and Coinsurance; and
   ii. Covered services are also provided for other immunizations, including immunizing agents, which are determined to be Medically Necessary;

b. <u>Routine Gynecological Examinations and Pap Smears</u>
   Female Participants are covered for gynecological examinations, including pelvic examinations and clinical breast examinations, routine Pap smears. Covered services which are provided by a Contracting Provider are exempt from Deductibles, Copayments, and Coinsurance;

c. <u>Screening Mammograms</u>
   Screening mammograms, including digital breast tomosynthesis ("3D mammography"), are covered for all Participants whether or not directed toward a definite condition of Disease or Injury. Covered services

which are provided by a Participating Provider are exempt from all Deductibles, Copayments and Coinsurance;

d. Colorectal Cancer Screening
Coverage for colorectal cancer screening is provided for covered individuals. Coverage for non-symptomatic covered individuals shall include, but is not limited to:

i. One (1) fecal occult blood test per Benefit Period;
ii. Sigmoidoscopy, screening barium enema, colonoscopy, or a test consistent with approved medical standards and practices to detect colon cancer, at a frequency determined by the covered individuals Physician;
iii. Coverage for symptomatic covered individuals shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating Physician; and
iv. Screenings for colorectal cancer for non-symptomatic individuals are exempt from all Deductibles, payments and Coinsurance, when provided by a Contracting Provider.

e. Prostate Cancer Screening
Coverage is provided for one (1) prostate specific antigen (PSA) and/or one (1) digital rectal exam per Benefit Period. Covered services are exempt from all Deductibles, Copayments and Coinsurance, when provided by a Contracting Provider;

f. Preventive Drugs
Covered services are provided for those generic preventive Drugs with a prescription, which as determined by the U.S. Preventive Services Task Force have a rating of A or B, in accordance with the Affordable Care Act of 2010.

Covered services are also provided for all FDA-approved contraceptives Drugs and methods, in accordance with the Health Resources and Services Administration's (HRSA) Women's Preventive Services: Required Health Plan Coverage Guidelines. The Summary of Benefits indicates whether contraceptives are covered. If contraceptives are not covered, coverage will not be provided for any Prescription Drug or supply including all dosage forms of contraceptives.

These generic preventive Drugs are exempt from Deductibles, Copayments, and Coinsurance, when dispensed by a participating pharmacy.

In order to receive covered services, the Participant must present the Prescription and the Network Identification Card to a participating pharmacy and the claim must be filed by a participating pharmacy;

g. Nutritional Therapy
Nutritional therapy to promote a healthy diet is available to Participants, when provided by a licensed health care professional, up to the Maximum as indicated in the Summary of Benefits. Covered services are exempt from all Deductibles, Coinsurance and Copayments, when provided by Contracting Providers.

Diabetes Outpatient self-management training and education and Nutritional Therapy provided to a Homebound Participant, as described in Medical Benefits section, are exempt from this Benefit Maximum.

Coverage for Dependent Children, who are covered under the Plan, will be provided as follows:
i. Dependent Children, ages two (2) through twelve (12), when accompanied by a parent; and
ii. Dependent Children, ages thirteen (13) through seventeen (17), with parental consent.

No coverage is provided for Dependent Children under the age of two (2);

26. **Retail Clinic Care**
Covered services are provided for Retail Clinic Care visits and consultations rendered and billed by a Professional Provider to a Participant who is an Outpatient or as indicated in the Summary of Benefits. Covered services are provided for the examination, Diagnosis, and treatment of common minor ailments. A primary care office visit Copayment applies per visit;

27. **Routine Patient Costs for Participation in an Approved Clinical Trial.** Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Plan Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, provided:

    a. The clinical trial is approved by:
        i. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
        ii. The National Institute of Health;
        iii. The U.S. Food and Drug Administration;
        iv. The U.S. Department of Defense;
        v. The U.S. Department of Veterans Affairs; or
        vi. An Institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and
    b. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

    Coverage will not be provided for:

    a. The cost of an Investigational new Drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a Drug or device that is the subject of the Approved Clinical Trial;
    b. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;
    c. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis;
    d. A cost associated with managing an Approved Clinical Trial;
    e. The cost of a health care service that is specifically excluded by the Plan; or
    f. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial;

28. **Second Surgical Opinion**
Second opinion consultations for Surgery to determine the Medical Necessity of an elective Surgical Procedure are covered. Elective Surgery is Surgery that is not for an Emergency or life-threatening condition.

    Such covered services must be performed and billed by a Professional Provider other than the one who initially recommended performing the Surgery;

29. **Skilled Nursing Facility**
Covered services are provided for care in a Skilled Nursing Facility, when determined to be Medically Necessary by the Plan, as indicated in the Summary of Benefits. The Participant must require treatment by skilled nursing personnel, which can be provided only on an Inpatient basis in a Skilled Nursing Facility. Pre-Certification procedures apply as set forth in the Cost Containment section.

The Participant's attending Physician must provide the Plan with clinical information that skilled nursing care in a Skilled Nursing Facility is Medically Necessary pursuant to the Cost Containment section.

No covered services are payable:

a. After the Participant has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine Custodial Care;
b. When confinement in a Skilled Nursing Facility is intended solely to assist the Participant with the activities of daily living or to provide an institutional environment for the convenience of a Participant; or
c. For the treatment of alcoholism, drug addiction, or mental Illness;

30. Surgery

a. Surgical Covered Services

Surgery covered services will be provided for services rendered by a Professional Provider and/or Facility Provider in a Physician's office or in a short procedure unit, Hospital, Outpatient department, or Freestanding Outpatient Facility for the treatment of Disease or Injury. Separate payment will not be made for Inpatient pre-operative care or all post-operative care normally provided by the surgeon as part of the Surgical Procedure.

For questions concerning Pre-Certification, the Participant should contact the Third-Party Administrator prior to the service being rendered. Ambulatory Surgery (i.e., Surgery performed in an acute-care Hospital's short procedure unit or a free-standing surgical facility) requires Pre-Certification by the Plan for certain procedures, regardless of Provider. Outpatient Surgery (i.e., Surgery performed in a Physician's office or in an acute-care Hospital's Outpatient department) also requires Pre-Certification of certain procedures by the Plan regardless of Provider.

i. Upon Pre-Certification, Surgery covered services are covered for the surgical treatment of Morbid Obesity, provided the Participant is at least eighteen (18) years of age or as indicated in the Summary of Benefits.
ii. Reconstructive Surgery will only be covered when required to restore function following Accidental Injury, infection, or Disease in order to achieve reasonable physical or bodily function; in connection with congenital Disease or anomaly through the age of eighteen (18) unless specifically stated as not covered in Exclusions; or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a Mastectomy;
iii. Covered Surgical Procedures shall also include routine neonatal circumcision or as indicated in the Summary of Benefits. Voluntary Surgical Procedures for sterilization regardless of Medical Necessity and Surgery performed for the reversal of sterilization are not covered or as indicated in the Summary of Benefits; and
iv. Covered services are provided for a Mastectomy performed on an Inpatient or Outpatient basis, and for the following:
    (1) Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy;
    (2) Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, due to a Mastectomy; and
    (3) Physical complications of all stages of Mastectomy, including lymphedemas. Coverage is also provided for one (1) home health care visit, as determined by the Participant's Physician, received within forty-eight (48) hours after discharge.
    (4) The orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft Surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus is covered.

v. Gender Reassignment Surgery: Coverage will be provided for gender reassignment surgery as the same cost sharing as other surgical procedures, subject to medical necessity. This modification is intended to comply with Section 1557 of the Affordable Care Act (ACA).

   Surgical Coverage is limited to the following procedures: Bilateral mastectomy or breast reduction, Clitoroplasty, Hysterectomy, Labiaplasty, Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of Gender Dysphoria, Metoidioplasty, Orchiectomy, Penectomy, Penile prosthesis, Phalloplasty, Salpingo-oophorectomy, Scrotoplasty, Testicular prostheses, Urethroplasty, Urethroplasty, Vaginectomy, Vaginoplasty, and Vulvectomy.

b. Assistant Surgeon
   Covered services will be payable for services by an assistant surgeon who actively assists the operating surgeon in the performance of covered Surgery for a Participant. The condition of the Participant or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Plan. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another Surgical Procedure during the same operative session;

c. Physician, Hospital or Ambulatory Surgical Facility Charges for Dental Procedures or Dental Surgery

   Dental procedures are not covered as set forth in the Exclusions or as specified by the Plan Specific Exclusions. Covered services will be payable for Physician, Hospital or Ambulatory Surgical Facility charges in connection with dental procedures or dental Surgery performed in a Hospital or Ambulatory Surgical Facility for:

   i. Children under the age of eighteen (18);
   ii. Adults with significant cognitive impairment;
   iii. Participants with complex medical conditions, when performing the Surgery/procedure in any setting other than a Hospital or Ambulatory Surgical Facility would present an unacceptable risk to the patient's health; or
   iv. When one of the following is present:
      (1) It is a required part of a broader treatment plan requiring radiation of the head and/or neck.
      (2) There is non-dental Disease eroding or invading the maxilla and/or mandible, the treatment of which necessitates removal of the Participant's teeth.
      (3) There is infection of the teeth and gums that places the Participant's health at risk if uncorrected prior to other Medically Necessary treatment such as but not limited to Chemotherapy or transplant.

e. Dental Services Related to Accidental Injury
   Dental services rendered by a Professional Provider and/or a Facility Provider, as a result of Accidental Injury to the jaws, natural teeth, mouth or face, are covered when performed for immediate post Injury stabilization. Injury as a result of chewing or biting shall not be considered an Accidental Injury.

   Dental implants are excluded from benefits as set forth in the General and Medical Limitations and Exclusions;

f. Dental Services Related to Early Childhood Caries (ECC)
   Dental services directly associated with early childhood caries (ECC), prior to age four (4), are limited to one (1) treatment per Participant per lifetime;

g. Eyeglasses or Contact Lenses following Surgery

Coverage will be provided for eyeglasses or contact lenses which perform the function of a human lens lost as a result of ocular Surgery (i.e., cataract Surgery) or Injury; pinhole glasses prescribed for use after Surgery for detached retina; lenses prescribed in lieu of Surgery for the following:

v. Contact lenses used for treatment of infantile glaucoma;
vi. Corneal or scleral lenses prescribed in connection with the treatment of keratoconus;
vii. Scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
viii. Corneal or scleral lenses to reduce a corneal irregularity other than astigmatism (for example, B & L Griffon Softcon Bandage Type Lenses).

Coverage will be provided for the initial prescription of cataract glasses or contact lenses, with or without an implant, after cataract Surgery. Post-cataract prescription glasses or contact lenses are limited to a Lifetime Benefit Maximum as the Summary of Benefits indicates. This Maximum allowance includes both eyes;

31. Therapeutic Drugs That are Not Self-Administrable

Covered services are provided for FDA-approved therapeutic Drugs, including cancer Chemotherapy and cancer hormone treatment that are not self-administrable and required in the treatment of an Illness or Injury in all medically appropriate treatment settings covered by the Plan;

32. Therapy Services--Outpatient

Covered services shall be provided for the following services prescribed by a Physician and performed by a Professional Provider and/or Facility Provider, which are used in treatment of an Illness or Injury to promote recovery of the Participant.

a. Radiation Therapy, including the cost of radioactive materials; and
b. Short term therapy is Occupational or Speech Therapy which:
    i. Is prescribed by a Physician;
    ii. Is Medically Necessary to regain lost function after an Accidental Injury, Surgery, or an acute Illness; and
    iii. Will result in improvement in the Participant's condition within a period of three (3) months from the initiation of therapy.

c. Outpatient Occupational and Speech Therapy covered services are limited to:

    i. Occupational Therapy is limited to a Maximum as indicated in the Summary of Benefits per Benefit Period;
    ii. Speech Therapy is limited to a Maximum as indicated in the Summary of Benefits per Benefit Period.

33. Transplant Surgery

If a human organ or tissue transplant is provided from a human donor to a human transplant recipient:

a. When both the recipient and the donor are Participants, each is entitled to the covered services of the Plan;
b. When only the recipient is a Participant, both the donor and the recipient are entitled to the covered services of the Plan. The donor covered services are limited to only those not provided or available to the donor from any other source. This includes but is not limited to other insurance coverage, or coverage by the Network or any government program. Covered services provided to the donor will be charged against the recipient's coverage under the Plan to the extent covered services remain and are available under the Participant after the covered services of the recipient have been paid;

c. When only the donor is a Participant, the donor is entitled to the covered services of the Plan. The covered services are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or coverage by the Network or any government program available to the recipient. No covered services will be provided to the non-Participant transplant recipient;
d. If any organ or tissue is sold rather than donated to the Participant recipient, no covered services will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the Participant recipient's Plan limit; and
e. If the Participant's coverage includes Prescription Drug coverage, the immunosuppressant Drugs in connection with covered transplants will be provided under the Prescription Drug Coverage section of the Plan and the cost for these Drugs is detailed in the Summary of Benefits.

Pre-Certification is required as set forth in the Cost Containment section; and

34. Treatment for Alcohol and/or Drug Abuse and Dependency

Covered services are available to a Participant who is certified by a licensed Physician or licensed Psychologist as a person who requires Substance Abuse treatment. Certification and referral by a licensed Physician or licensed Psychologist control the nature and duration of treatment for Inpatient or Outpatient Substance Abuse treatment. The certification must be provided to PerformCare before claims for treatment rendered will be processed for payment. The certification by a licensed Physician or licensed Psychologist is valid as indicated in the Summary of Benefits. Any treatment beyond the limit as stated in the Summary of Benefits or any subsequent treatment must meet Medical Necessity requirements and will require Pre-Certification as described in Cost Containment.

Inpatient Detoxification, Inpatient Non-Hospital Residential Care and Intensive Outpatient requests for Drug and Alcohol treatment by non-Physicians/Psychologists must be pre-certified with PerformCare before services are rendered and must meet Medical Necessity criteria.

a. Inpatient Detoxification
Covered services are provided for Inpatient Detoxification when provided in either a Hospital or in an Inpatient Non-Hospital Residential Facility. The following services will be covered when administered by an employee of the facility:

i. Lodging and dietary services;
ii. Rehabilitation therapy and counseling;
iii. Diagnostic x-ray;
iv. Psychiatric, psychological and medical laboratory testing; and
v. Drugs, medicines, equipment use and supplies.

b. Inpatient Non-Hospital Residential Care
Covered services are provided for Inpatient Non-Hospital Residential Care in an Inpatient Non-Hospital Residential Facility.

The following services will be covered when administered by an employee of the facility:

vi. Lodging and dietary services;
vii. Physician, Psychologist, nurse, certified addiction counselors and trained staff services;
viii. Rehabilitation therapy and counseling;
ix. Family counseling and intervention;
x. Psychiatric, psychological and medical laboratory testing; and
xi. Drugs, medicines, equipment use and supplies.

c. Outpatient Facility Services for Treatment of Alcohol or Drug Abuse
Covered services are provided for Outpatient Alcohol and/or Drug Abuse services when provided in a Substance Abuse Treatment Center. The following services will be covered when administered by an employee of the facility:

xii. Physician, Psychologist, nurse, certified addiction counselors and trained staff services;
xiii. Rehabilitation therapy and counseling;
xiv. Family counseling and intervention;
xv. Psychiatric, psychological and medical laboratory testing; and
xvi. Drugs, medicines, equipment use and supplies.

35. Treatment for Autism Spectrum Disorders
Benefits are provided for all Participants under twenty-one (21) years of age for the following:

1. Diagnostic Assessment of Autism Spectrum Disorders
Medically Necessary and Appropriate assessments, evaluations or tests performed by a Physician, licensed physician assistant, Psychologist or certified registered nurse practitioner to diagnose whether an individual has an Autism Spectrum Disorder.

2. Treatment of Autism Spectrum Disorders
Services must be specified in a treatment plan developed by a Physician or Phycologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report of recommendation of the American Academy of Pediatrics. The Plan may review a treatment plan for Autism Spectrum Disorders once every six (6) months, or as agreed upon between the Plan and the Physician or Phycologist developing the treatment plan.

Treatment of Autism Spectrum Disorders may include the following Medically Necessary and Appropriate Services:

a. Pharmacy Care
Pharmacy care for Autism Spectrum Disorders includes any assessment, evaluation or test prescribed or ordered by a Physician, licensed physician assistant, Psychologist or certified registered nurse practitioner to determine the need or effectiveness of a Prescription Drug approved by the Food and Drug Administration and designated by the Plan for the treatment of Autism Spectrum Disorders.
b. Psychiatric and psychological care
Direct or consultative services provided by a Physician or Phycologist who specializes in psychiatry.
c. Rehabilitative care
Professional services and treatment programs, including Applied Behavioral Analysis, provided by an Autism Service provider to produce socially significant improvements in human behavior or to prevent loss of attained kill or function.
d. Therapeutic care
Services that are provided by a speech language pathologist, Occupational Therapist or Physical Therapist.

36. Telemedicine
Benefits are provided to all Participants for telemedicine visits via phone and video conferencing made by a Covered Person to a SwiftMD Physician. Expenses billed for the use of equipment or transmission charges to transmit the audio-visual information are not covered.

15.04 Cost Containment

15.04A Pre-Certification Procedures

For Inpatient Emergency admissions to a Non-Contracting Provider, the Participant is responsible for notifying the Plan or its designated agent within forty-eight (48) hours, of the Emergency Service or as soon as reasonably possible. Once the Participant is stabilized, to continue coverage at the higher reimbursement level, the Plan reserves the right to transfer the Participant's care from a Non-Contracting Provider to a Contracting Provider.

The telephone number for Pre-Certification for mental health care covered services is 1 (800) 577-3742. Pre-Certification for Home Infusion Therapy can be obtained by contacting the Pharmacy Management Department of First Priority Life at 1 (800) 577-3742 or at the following address:

Pharmacy Management Department
First Priority Life
19 North Main Street
Wilkes-Barre, PA 18711-0302

Pre-Certification of Services

1. Services
   Pre-Certification is required to determine Medical Necessity for services and in order to allow Participant to maximize benefits in the Plan.

   With the exception of an Emergency Service or a maternity admission, Pre-Certification is required for transplant Surgery and prior to Inpatient admissions in a Skilled Nursing Facility, Rehabilitation Hospital or Psychiatric Hospital regardless of whether the facility is a contracting or non-contracting facility. Pre-Certification is required prior to Inpatient admissions for certain diagnoses and Surgeries when performed as an Inpatient in a contracting facility. Pre-Certification is required for all Inpatient admissions in a non-contracting facility.

   Certain procedures/surgeries performed in an acute-care Hospital's short procedure unit or free-standing surgical facility and certain diagnostic tests/scans require Pre-Certification, regardless of whether the Provider is a Contracting or Non-Contracting Provider.

   Pre-Certification for Inpatient or Outpatient covered services is waived in the case of an Emergency Service or maternity admission. However, the Provider or the Participant must submit notification to First Priority Life of the Inpatient Emergency admission within forty-eight (48) hours or as soon as reasonably possible.

   Except for the Home Health Care visit following a Mastectomy or the postpartum visit, Pre-Certification is required for Home Health Care and for select Home Infusion Therapy services described in the Medical Benefits section regardless of whether the facility is a Contracting or Non-Contracting Provider. Certification refers only to the Medical Necessity of the services. Once the certified admission or treatment takes place, payment of covered services is subject to the Participant's eligibility on the date of service; and

2. Providers
   The Participant is responsible to confirm with a BlueCare Service Representative that their Provider obtained Pre-Certification prior to the service being rendered.

   Contracting Providers: Contracting Providers are responsible for obtaining Pre-Certification on behalf of a Participant. Contracting Providers must accept the Plan's determination of Medical Necessity. Contracting Providers may not bill the Participant for services, which the Plan determines are not Medically Necessary, unless, of course, the Insured or Provider received prior notice that the service or admission would not be covered but nonetheless elected to undergo the treatment or be admitted.

A Participant will not be responsible for payment to a Contracting Provider when the Pre-Certification was requested and the Plan denied the service or admission because it was not Medically Necessary, yet the Provider admitted the Participant or provided the treatment.

Non-Contracting Providers: The Participant is responsible to confirm with a Third-Party Administrator that their Non-Contracting Provider obtained Pre-Certification prior to the service being rendered. Non-Contracting Providers are not obligated to accept the Plan's determination, and therefore, may bill the Participant for services determined not to be Medically Necessary. The Participant is solely responsible for payment for such services. The Participant can avoid this responsibility by choosing a Contracting Provider.

15.04B Pre-Certification Penalty

The Participant is responsible to confirm with the Third-Party Administrator that their Provider obtained Pre-Certification prior to the service being rendered.

Contracting Providers: Contracting Providers are responsible for obtaining Pre-Certification on behalf of a Participant. These Providers must accept the Plan's determination of Medical Necessity and may not bill the Participant for services, which the Third-Party Administrator determines are not Medically Necessary, unless, of course, the Participant or Provider received prior notice that the service or admission would not be covered but nonetheless elected to undergo the treatment or be admitted.

A Participant will not be responsible for payment when the Pre-Certification was requested and the Plan denied the service or admission because it was not Medically Necessary, yet the Provider admitted the Participant or provided the treatment.

Non-Contracting Providers: The Participant is responsible to confirm with the Third-Party Administrator that their Non-Contracting Provider obtained Pre-Certification prior to the service being rendered. A Non-Contracting Provider is not obligated to accept the Plan's determination, and therefore, may bill the Participant for services determined not to be Medically Necessary. The Participant is solely responsible for payment for such services. The Participant can avoid this responsibility by choosing a Contracting Provider.

The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify the Pre-Certification department of any Inpatient stay at a Non-Contracting Hospital as required in the section entitled "Pre-Certification Procedures," allowed charges will be reduced by $500 for a facility penalty and 20% for a professional penalty. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan. Penalties for failure to obtain Pre-Certification will not be applied to the Participant's Coinsurance Maximum. The Plan only covers services that it determines to be Medically Necessary. Should the Participant fail to obtain Pre-Certification from a Non-Contracting Provider, as required, and it is determined that the service was not Medically Necessary, the Participant will be liable for the full cost of any services rendered.

15.04C Alternative Treatment Plan

Notwithstanding anything in the Plan to the contrary, the Network may elect to provide covered services pursuant to an approved Alternative Treatment Plan for services that would otherwise not be covered. All decisions regarding the implementation of alternative care or alternative treatment to be provided to a Participant shall remain the responsibility of the treating Physician and the Participant. The Participant has the right, at any time, to have the Alternative Treatment Plan discontinued.

The Network shall provide such alternative covered services only when and for so long as it determines that the services are Medically Necessary, cost effective relative to covered services that would otherwise be covered and subject to a documented Alternative Treatment Plan specifying the alternative covered services and their cost

efficacy. The total covered services paid for such services will not exceed the total covered services to which the Participant would otherwise be entitled under the Plan in the absence of alternative covered services.

If the Network elects to provide alternative covered services for a Participant in one instance, it shall not be obligated to provide the same or similar covered services for any Participant in any other instance, nor shall it be construed, as a waiver of its right to administer the Plan thereafter in strict accordance with its expressed terms.

15.04D Pre-Admission Testing

If a Participant is to be admitted to a Hospital for non-Emergency Surgery or treatment, one set of laboratory tests and x-ray examinations performed on an Outpatient basis within seven (7) days prior to such Hospital admission will be paid, with no Deductible, at one hundred percent (100%) of the Allowable Charge, provided that the following conditions are met:

1. The tests are related to the performance of the scheduled Surgery or treatment;
2. The tests have been ordered by a Physician after a condition requiring Surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital;
3. The Participant is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary; and
4. The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

15.04E Second Surgical Opinion

If a Physician recommends Surgery for a Participant, the Participant may request a second opinion as to whether or not the Surgery is Medically Necessary.

In addition, the Plan recommends that a second opinion be obtained prior to the following Surgeries:

1. Adenoidectomy;
2. Bunionectomy;
3. Cataract removal;
4. Coronary Bypass;
5. Cholecystectomy (removal of gallbladder);
6. Dilation and curettage;
7. Hammer Toe repair;
8. Hemorrhoidectomy;
9. Herniography;
10. Hysterectomy;
11. Laminectomy (removal of spinal disc);
12. Mastectomy;
13. Meniscectomy (removal of knee cartilage, including arthroscopic approach);
14. Nasal Surgery (repair of deviated nasal septum, bone or cartilage);
15. Prostatectomy (removal of all or part of prostate);
16. Release for entrapment of medial nerve (Carpal Tunnel Syndrome);
17. Tonsillectomy; and
18. Varicose veins (tying off and stripping).

When a second opinion is requested, the Plan will pay 100% of the Allowable Charge Incurred for that opinion along with laboratory, x-ray and other Medically Necessary services ordered by the second Physician without application of the Deductible. Second opinions for Cosmetic Surgery, normal obstetrical delivery and Surgeries that require only local anesthesia are not covered. If the second opinion does not concur with the first, the Plan will pay for a third opinion as outlined above. The second or third opinion must be given within ninety (90) days of the first.

In all cases where a second opinion is requested, the original recommendation for Surgery must have been obtained from a Physician licensed in the medical specialty under which the recommended Surgery falls. The Physician consulted for the second opinion must be licensed in the same medical specialty and may not be a partner of or in association with the original Physician.

15.04F Pre-Surgical Approval

The Plan recommends that a pre-determination of benefits be obtained prior to the following surgical procedures, since they are usually Cosmetic Surgery or not Medically Necessary. These procedures include, but are not limited to:

1. Abdominoplasty;
2. Blepharoplasty;
3. Breast reduction or enlargement;
4. Dermabrasion;
5. Facial or nasal reconstruction;
6. Gastric bypass;
7. Lipectomy;
8. Penile implant;
9. Scar revision;
10. Sex alteration; or
11. Any Experimental or research procedures which are not generally accepted medical practice.

Because of the broad range of surgical procedures available and under development, if a Participant is scheduled to undergo any questionable procedure, he or she should contact the Third-Party Administrator for further information.

ARTICLE XVI
PRESCRIPTION DRUG BENEFITS

16.01 Prescription Drug Benefit Summary

		Limitations
Deductible per person	None	
Deductible per family	None	
Total Individual Maximum Out-of-Pocket	$1,800	Includes Rx deductible, Rx coinsurance, and Rx copays.
Total Family Maximum Out-of-Pocket	$3,600	Includes Rx deductible, Rx coinsurance, and Rx copays. No one person pays more than the individual amount and no family pays more than the aggregate family amount.
Yearly maximum	None	
Lifetime maximum	None	
Formulary	Multi-tier	
Retail	Covered	30 day supply
Generic Copay	$10	
Formulary Brand Copay	$20	
Non-Formulary Brand Copay	$35	
Mail Order	Covered	Up to 90 day supply
Generic Copay	$10	
Formulary Brand Copay	$40	
Non-Formulary Brand Copay	$70	
Contraceptives	Covered	Excluding non-drug containing devices
Exclusive Home Delivery	Does not apply	
Select Home Delivery	Does not apply	
Generic Preferred	Does not apply	
Quantity Management Limits	Applies	Certain medications identified on the prescription drug formulary apply a quantity limit
Specialty Injectable Network	Does not apply	
Metabolic Supplement	Not covered	
Step Therapy	Does not apply	
Prior Authorization	Applies	Certain medications identified on the prescription drug formulary as requiring Prior Authorization.
Vaccine Program	Applies	Vaccines are provided and administered by pharmacists contracted to administer vaccines.
Weight Loss Drugs	Covered	

		Limitations
Other		Injectable infertility Drugs are covered. Prescription preventive schedule applies

16.02 Definitions

The following words and phrases when used in the Plan shall have, unless the context clearly indicates otherwise, the meaning given to them below:

1. **Covered Pharmacy Expense –** A service or supply specified in the Plan for which covered services for Prescription Drugs and supplies will be provided pursuant to the terms of the Plan;

2. **Drug Formulary –** A listing of Preferred Prescription Drugs and supplies covered by the Plan, which is subject to periodic review and modification at least annually by a committee of appropriate actively practicing preferred Physicians and Pharmacists. Prescription Drug inclusions in the Drug Formulary are based on a combination of criteria including clinical quality and cost effectiveness. The Drug Formulary is available upon request from Express Scripts Service Representatives by calling toll-free 1 (877) 603-8399 or via the Network's website, www.highmarkbcbs.com.

3. **Generic Equivalent Prescription Drug –** Any Prescription Drug that is considered to be therapeutically equivalent to other pharmaceutical equivalent products by the Food and Drug Administration, has received an "A Code" in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations," and is in compliance with applicable state generic substitution laws and regulations;

4. **Maintenance Prescription Drug –** Any Prescription Drug, not including Specialty Injectable Drugs, which the Plan makes available through a Participating Mail Order Pharmacy, which is generally used to treat chronic medical conditions and is generally not needed urgently for an immediate acute Illness and which the Participant chooses to obtain, or the Plan requires be obtained, from a Participating Mail Order Pharmacy. The Plan may specify certain Prescription Drugs that are not available through a Participating Mail Order Pharmacy;

5. **Medically Necessary** - Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

   a. The Drug is approved by the FDA;
   b. The prescribed Drug use is supported by one of the following standard reference sources:
      i. DRUGDEX;
      ii. The American Hospital Formulary Service Drug Information;
      iii. Medicare approved Compendia; or
      iv. Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition; and
   c. The Drug is Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

6. **Non-Preferred Prescription Drug –** Any Prescription Drug listed as a non-formulary brand of the Plan Drug Formulary;

7. **Participating Community Pharmacy Provider –** Any Participating Pharmacy Provider, which is a public, walk-in Pharmacy;

8. **Participating Mail Order Pharmacy Provider –** A Participating Pharmacy, which has entered into a Participating Mail Order Pharmacy agreement with the Plan;

9. **Participating Pharmacy Provider –** Any Pharmacy, which has entered into a Participating Pharmacy agreement with the Plan or other entity contracted by the Plan to furnish a Pharmacy Provider Network. Participating Pharmacy Providers include: Participating Community Pharmacy Providers, Participating Mail Order Pharmacy Providers and Participating Pharmacy Providers for Specialty Drugs;

10. **Participating Pharmacy Provider for Specialty Drugs –** A Participating Pharmacy Provider, which has entered into a Specialty Drug Provider agreement with the Plan;

11. **Pharmacist –** An individual who has been issued a license by the appropriate state licensing agency to engage in the practice of pharmacy, including the preparation and dispensing of Prescription Drugs and the dissemination of Drug information to patients and health professionals;

12. **Pharmacy –** An establishment which has been issued a permit by the appropriate state licensing agency wherein the practice of pharmacy is conducted under the direct supervision and control of a licensed Pharmacist;

13. **Preferred Prescription Drug –** Any Prescription Drug, which is listed in the Drug Formulary and preferred by the Plan;

14. **Prescriber –** An individual who has been issued a license by the appropriate state licensing agency to engage in a health care professional practice, who, acting within the scope of his/her license, is duly authorized by law to prescribe Prescription Drugs;

15. **Prescription –** An order from a Prescriber for a single Prescription Drug of a particular strength and/or dosage form;

16. **Prescription Drug –** Any medication, which by federal and/or state law may not be dispensed without a Prescription order issued by a Prescriber;

17. **Prescription Drug Copayment –** The amount a Participant must pay directly to Pharmacy Providers in connection with Covered Pharmacy Expenses as set forth in the Prescription Drug Benefit Summary;

18. **Prescription Drug Maximum –** The greatest covered service amount payable by the Plan for Covered Pharmacy Expenses as set forth in the Prescription Drug Benefit Summary;

19. **Prior Authorization –** With regard to Prescription Drug covered services, Prior Authorization means the process whereby the Prescriber and/or the Participant is given prior approval by the Plan for certain Prescription Drugs, including Drug Formulary exceptions, and utilization review criteria, which have been designated by the Plan as requiring Prior Authorization; and

20. **Specialty Drug –** Any Prescription Drug, which has been specifically designated by the Plan as being available from only a Participating Pharmacy for Specialty Drugs. Such Prescription Drugs classes include, but are not limited to self-administrable injectables, such as antihemophilic agents, hematopoietic agents, anticoagulants, growth hormones, enzyme replacement agents, immunomodulators, immunosuppressives, monoclonal antibodies, and other biotech Drugs. From time-to-time, such as when new biotech Drugs become available, the Plan may specify certain Prescription Drugs that are available from only a Participating Pharmacy for Specialty Drugs.

16.03 Schedule for Covered Pharmacy Expenses

Except for special circumstances described in the following section, Prescription Drugs with Mail Order, Prescription Drugs dispensed by a non-participating Pharmacy are not covered. Covered services will be provided for covered

Prescription Drugs dispensed by a Participating Pharmacy in the amount specified in the Prescription Drug Benefit Summary.

There may be a Copayment specific to self-administrable Prescription Drugs and supplies, including Specialty Drugs. The Prescription Drug Copayment, payable directly to the Participating Pharmacy or to a Participating Mail Order Pharmacy for Maintenance Prescription Drugs, is outlined in the Prescription Drug Benefit Summary. This Prescription Drug Copayment is not subject to the Coinsurance limitation for Covered Services set forth in the Medical Benefits section.

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Prescription Drugs-Retail/Mail Order

Covered services will be provided for covered Prescription Drugs dispensed by a Participating Pharmacy in the amounts specified in the Prescription Drug Benefit Summary, as follows:

1. Covered Drugs/supplies include: (a) Prescription Drugs which can be self-administered, including contraceptives for the use of birth control, if so specified in the Summary of Benefits, (b) insulin, (c) disposable syringes/needles for the administration of covered Prescription Drugs and insulin, (d) lancets, (e) glucose test strips, sensors, (f) spacer devices for use with metered-dose inhalers, (g) peak flow meters, (h) other Drugs/supplies which may be specifically designated by the Plan, and (i) the covered pharmaceutical services necessary to make such Drugs available, not including, however, any Drug or group of Drugs specifically excluded by the terms of the Plan;

2. Supply limits:
    a. Each Prescription Drug is limited to a thirty (30) day supply based on the Prescriber's directions for use and further subject to the quantity limits authorized by the Prescriber on the Prescription order, maximum daily dosages as indicated in the Drug information literature, and/or quantity limits allowed by the Plan; and
    b. Each Maintenance Prescription Drug is limited to a ninety (90) day supply based on the Prescriber's directions for use and further subject to the quantity limits authorized by the Prescriber on the Prescription order, maximum daily dosages as indicated in the Drug information literature, and/or quantity limits allowed by the Plan;

3. Prescriptions are refillable for a period not in excess of one (1) year from the date written and further subject to refill limitations as set forth in federal and/or state law or by the Prescriber;

4. Unless the Prescriber or Pharmacist has requested and received Prior Authorization for an early refill, the claim will be denied if a refill is requested before the time seventy-five percent (75%) of the days' supply of medication has passed. An early refill Prior Authorization can be granted for an additional supply for reasons such as vacation or business travel. A Participating Pharmacy may receive authorization by telephone to fill the prescription early on a one-time-only basis any time before the next regular refill due-date;

5. In order to receive covered services, the Participant must present the Network Identification Card to a Participating Pharmacy and the claim must be filed by a Participating Pharmacy, except in special circumstances and such other situations as deemed appropriate by the Plan. In special circumstances, such as when a Participant needs an unexpected Prescription when beyond a reasonable distance from a Participating Pharmacy, while vacationing or traveling Out-of-Area, inaccessibility to a Participating Pharmacy, inaccessibility of the Network electronic claims/eligibility systems, or for urgent or Emergency needs, the Participant may request reimbursement for purchased Prescriptions from the Plan. Reimbursement will not be in excess of the amount which would otherwise have been payable to a Participating Pharmacy for the Prescription Drug, less the Copayment. Such requests are subject to a filing limit of one (1) year from the date of purchase; and

6. All Prescription Drug claims are subject to prospective, concurrent and/or retrospective Drug utilization review by health care professionals, and further may require Prior Authorization to determine if a Prescription Drug is Medically Necessary. Before prescribing the Prescription Drug, a Participating Prescriber will advise the Participant if Prior Authorization is required and request the Prior Authorization on behalf of the Participant. Participating Prescribers initially accept the Plan's determination of Medical Necessity. In the event the Prior Authorization is denied for lack of Medical Necessity, no covered services will be provided by the Plan when the Participant disregards the Prior Authorization denial and elects to purchase the Prescription Drug. Should a Prescription Drug, which requires Prior Authorization, be presented to a Participating Pharmacy without Prior Authorization, the Participating Pharmacy will advise the Participant prospectively that the claim was denied by the Plan because Prior Authorization is required for coverage of the Prescription Drug.

No covered services will be provided by the Plan when the Participant elects not to have the Participating Prescriber obtain prior authorization, disregards the Participating Pharmacy's notification of the claim denial and elects to purchase the Prescription Drug.

16.04 Prescription Drug Exclusions

Prescription Drug exclusions follow.

1. Charges for any Prescription Drug or supply, which is not Medically Necessary and appropriate based on one (1) or more of the following reasons:
    a. The indication and/or use is of a cosmetic nature or to enhance physical appearance, to enhance athletic performance, or for weight loss;
    b. Based on the Pharmacist's professional judgment, the Prescription should not be dispensed; or
    c. The Prescription Drug or supply is subject to Prior Authorization and has not been authorized as an exception, (based on, and supported by, medical justification from the Prescriber) for the following reasons:
        i. The use of the Prescription Drug or supply is contraindicated due to overutilization, drug-drug interaction, drug-disease interaction, therapeutic duplication, adverse reaction, or drug allergy; or
        ii. The use of the Prescription Drug or supply is subject by the Plan's utilization review criteria;

2. Charges for any Prescription Drug or supply, unless authorized in accordance with the Plan, which are:
    a. Experimental or Investigative;
    b. Not approved for use by the Food and Drug Administration; or
    c. Not approved for the specific indication by the Food and Drug Administration;

3. Unless specifically included in the Medical Benefits section of this Plan, the following are excluded as Covered Pharmacy Expenses:
    a. Drugs which do not require a Prescription;
    b. Drugs which cannot be self-administered;
    c. Medical supplies, devices and equipment;
    d. Test agents and devices, except those used for diabetes;
    e. Smoking-cessation aids, including nicotine patches, gums and nasal sprays, except Prescription Drugs specifically designated by the Plan which are covered for one treatment period per lifetime;
    f. Multiple vitamins, except those used for Pregnancy and multiple vitamins with fluoride for the prevention of dental caries in Children under the age of sixteen (16);
    g. Injectable Drugs used to treat fertility;
    h. Drugs for impotence;
    i. Allergy extracts for allergen immunotherapy;

j. Administration or injection of any Drugs;
k. Replacement of lost, stolen or damaged Drugs; and
l. Take home Drugs dispensed by a Facility Provider or Professional Provider.

16.05 Women's Preventive Services

All FDA-approved contraceptives Drugs and methods are covered in accordance with the Health Resources and Services Administration's (HRSA) Women's Preventive Services: Required Health Plan Coverage Guidelines. Coverage is for a defined, finite list of generic hormonal and emergency contraceptives, Mirena (intra-uterine device), and diaphragms.

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ARTICLE XVII HIPPA PRIVACY

The Plan provides each member with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by calling (570) 941-7767.

Definitions

Breach means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
8. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
13. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
    b. In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health

information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third-Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:
Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information; and
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.
4. If the Plan maintains psychotherapy notes: Most uses and disclosures of psychotherapy notes.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
    a. a public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;
    b. report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
    c. locate and notify persons of recalls of products they may be using; and
    d. a person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;
3. The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be

circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI;

4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;
5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;
6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;
7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for fifty (50) years;
8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions;
9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;
10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and
11. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Participant; and

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed From Participants Before Disclosing PHI

1. **Uses and disclosures for marketing;**
2. **Sale of PHI; and**

3. **Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.**

Participant's Rights
The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;
2. Right to Receive Confidential Communication: The Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests;
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator;
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six (6) years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Compliance Coordinator;
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within thirty (30) days (in some cases, the Plan can request a thirty (30)-day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial;
6. Amendment: The Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and
7. Fundraising contacts: The Participant has the right to opt out of fundraising contacts.

Questions or Complaints
If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Compliance Coordinator Contact Information:
University of Scranton
Benefits Manager of Human Resources
800 Linden Street
Scranton, PA 18510-4679
Phone: (570) 941-7767
Fax: (570) 941 4636

ARTICLE XVIII
HIPAA SECURITY

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (“SECURITY RULE”)

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

1. “*Electronic Protected Health Information*” (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.
2. “Security Incidents” is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware; and
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Participant whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach. Breach Notification must be provided to individual by:
    a. Written notice by first-class mail to Participant (or next of kin) at last known address or, if specified by Participant, e-mail;
    b. If Plan has insufficient or out-of-date contact information for the Participant, the Participant must be notified by a “substitute form;”
    c. If an urgent notice is required, Plan may contact the Participant by telephone.
        i. The Breach Notification will have the following content:

    1. Brief description of what happened, including date of breach and date discovered;
    2. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
    3. Steps Participant should take to protect from potential harm; and
    4. What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches;
2. Notify the media if the breach affected more than five hundred (500) residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered;
3. Notify the HHS Secretary if the breach involves five hundred (500) or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than five hundred (500) individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within sixty (60) days after the end of each Calendar Year; and
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach so that the affected Participants may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

ARTICLE XIX
ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage
Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You should be provided a Certificate of Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Participants and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

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

order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

ARTICLE XX
COBRA CONTINUATION RIGHTS

INTRODUCTION

This notice contains important information about Your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it**.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You and other members of Your family when group health coverage would otherwise end. For more information about Your rights and obligations under the Plan and under federal law, You should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower Out-of-Pocket costs. Additionally, You may qualify for a 30-day Special Enrollment period for another group health plan for which You are eligible (such as a Spouse's plan), even if that plan generally doesn't accept Late Enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event. This is also called a “qualifying event”. Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, Your Spouse, and Your Dependent Child(ren) could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You're an Employee, You'll become a qualified beneficiary if You lose Your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You're the Spouse of an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because of the following qualifying events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from Your Spouse.

Your Dependent Child(ren) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
  - The parent-Employee's employment ends for any reason other than his or her gross misconduct;
  - The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
  - The Child stops being eligible for coverage under the plan as a “Dependent Child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's Spouse, surviving Spouse, and Dependent Child(ren) will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Sponsor has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the Employer (if the Plan provides retiree coverage), or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Sponsor of the qualifying event.

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), You must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice in writing to the Plan Administrator. IF YOU, YOUR SPOUSE OR YOUR DEPENDENT FAIL TO PROVIDE TIMELY WRITTEN NOTICE TO THE PLAN ADMINISTRATOR AFTER A DIVORCE, LEGAL SEPARATION OR LOSS OF DEPENDENT CHILD ELIGIBILITY, THE RIGHT TO ELECT TO PURCHASE COBRA CONTINUATION COVERAGE IS WAIVED.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Sponsor receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Child(ren).

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Plan Sponsor in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the determination of disability by the Social Security Administration must be sent to the Plan Sponsor within 60 days after the date the determination is issued and before the end of the 18-month maximum coverage period that applies to the qualifying event. Any individual who is either the Employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the Employee or qualified beneficiary, may send the written notice to the Plan Sponsor. Such individual(s) must further notify the Plan Sponsor in writing within 30 days after a determination has been made that the person is no longer disabled. The Plan may require the payment of an amount that is up to 150 percent of the applicable premium for the period of extended coverage as long as the disabled individual is included in the extended coverage period.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent Child(ren) in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the Spouse and any Dependent Child(ren) receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes, instead of enrolling in COBRA continuation coverage, there may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "Special Enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about these options at www.HealthCare.gov.

You should compare Your other coverage options with COBRA continuation coverage and choose the coverage that is best for You. For example, if You move to other coverage, You may pay more out of pocket than You would under COBRA because the new coverage may impose a new deductible.

When You lose job-based health coverage, it's important that You choose carefully between COBRA continuation coverage and other coverage options, because once You've made Your choice, it can be difficult or impossible to switch to another coverage option.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace allows You to find and compare private health insurance options. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums and cost-sharing reductions (amounts that lower Your Out-of-Pocket costs for deductibles, coinsurance, and copayments) right away, and You can see what Your premium, deductibles, and Out-of-Pocket costs will be before You make a decision to enroll. Through the Marketplace You'll also learn if You qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for Your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage.

WHEN CAN I ENROLL IN MARKETPLACE COVERAGE?

You always have 60 days from the time You lose Your job-based coverage to enroll in the Marketplace. That is because losing Your job-based health coverage is a "Special Enrollment" event. **After 60 days Your Special Enrollment period will end and You may not be able to enroll, so You should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what You need to know about qualifying events and Special Enrollment periods, visit www.HealthCare.gov.

IF I SIGN UP FOR COBRA CONTINUATION COVERAGE, CAN I SWITCH TO COVERAGE IN THE MARKETPLACE? WHAT ABOUT IF I CHOOSE MARKETPLACE COVERAGE AND WANT TO SWITCH BACK TO COBRA CONTINUATION COVERAGE?

If You sign up for COBRA continuation coverage, You can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end Your COBRA continuation coverage early and switch to a Marketplace plan if You have another qualifying event such as marriage or birth of a child through something called a "Special Enrollment period." But be careful though - if You terminate Your COBRA continuation coverage early without another qualifying event, You'll have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once You've exhausted Your COBRA continuation coverage and the coverage expires, You'll be eligible to enroll in Marketplace coverage through a Special Enrollment period, even if Marketplace open enrollment has ended.

If You sign up for Marketplace coverage instead of COBRA continuation coverage, You cannot switch to COBRA continuation coverage under any circumstances.

WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?

When considering Your options for health coverage, You may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a Spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If You're currently getting care or treatment for a condition, a change in Your health coverage may affect Your access to a particular health care Provider. You may want to check to see if Your current health care Providers participate in a Network as You consider options for health coverage.

- Drug Formularies: If You're currently taking medication, a change in Your health coverage may affect Your costs for medication – and in some cases, Your medication may not be covered by another plan. You may want to check to see if Your current medications are listed in Drug formularies for other health coverage.
- Severance payments: If You lost Your job and got a severance package from Your former employer, Your former employer may have offered to pay some or all of Your COBRA payments for a period of time. In this scenario, You may want to contact the Department of Labor at 1-866-444-3272 to discuss Your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if You move to another area of the country, You may not be able to use Your benefits. You may want to see if Your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, You probably pay copayments, deductibles, coinsurance, or other amounts as You use Your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect Your family's rights, let the Plan Sponsor know about any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You sent to the Plan Sponsor.

PLAN CONTACT INFORMATION

If You have any questions regarding COBRA Continuation Coverage under the Plan, please contact Your Plan Sponsor.

ARTICLE XXI
COMPLIANCE NOTICES

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 Pre-Certification. For information on Pre-Certification, contact Your Plan Administrator.

Source Of Injury Restrictions

The Plan will not limit coverage for Injuries or Illnesses resulting from 1) domestic violence, or 2) self-inflicted Injury or attempted suicide. Further, the Plan will not limit coverage for Injuries or Illnesses resulting from participation in any activity if such Illness or Injury is as a result of a covered physical or mental condition.

Wellness and Risk factors

The Plan will not charge Covered Persons who have adverse health factors, or who participate in certain adverse lifestyle activities, more than those similarly situated Covered Persons who do not have such factors or participate in such activities.* Further, the Plan will not provide rewards to Covered Persons who participate in, or meet the requirements of, positive lifestyle activities in excess of what is offered to those similarly situated Covered Persons who do not participate in, or meet the requirements of, such activities.*

* Except as such differential treatment is allowed through the incorporation of wellness program(s) meeting federally approved guidelines.

Family Medical Leave Act (FMLA)

If the Covered Person is entitled to, and elects to take, a family or medical leave solely under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Covered Person and his covered Dependents shall continue to be covered under this Plan while the Covered Person is absent from work on an FMLA Leave as if there were no interruption of active employment. Provided the applicable premium is paid, such coverage will continue until the earlier of the expiration of such leave or the date notice is given to the Employer that the Covered Person does not intend to return to work at the end of the FMLA Leave.

The Covered Person may choose not to retain health coverage during the FMLA Leave. If he returns to active working status on or before the expiration of the leave, he is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. (Coverage will be reinstated without any additional qualification requirements imposed by this Plan. This Plan's provisions with respect to Deductibles and percentage of payments will apply on the same basis as they did prior to the FMLA Leave.)

Military Leave (USERRA)

If You are absent from work due to military service, You may elect to continue coverage under the Plan (including coverage for enrolled Dependents) for up to 24 months from the first day of absence (or, if earlier, until the day after the date You are required to apply for or return to active employment with Your Employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)). Your contributions for continued coverage will be the same as for a COBRA beneficiary, except that, if You are absent for 30 days or less, Your contribution will be the same as for similarly situated active Participants in the Plan.

Whether or not You continue coverage during military service, You may reinstate coverage under the Plan on Your return to employment under USERRA. The reinstatement will be without any Waiting Period otherwise required under the Plan, except to the extent that You had not fully completed any required Waiting Period prior to the start of military service.

Genetic Information

In accordance with the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information, the Plan may not adjust premium or contribution amounts for those covered under the Plan based on Genetic Information. The Plan may also not request, require, or purchase Genetic Information for underwriting purposes (or in connection with any individual prior to such individual's enrollment under the Plan). The term "underwriting" covers rules relating to the determination of eligibility (including enrollment and continued eligibility) for Plan benefits or coverage, the computation of premium or contribution amounts and any activities relating to the creation, renewal, or replacement of the Plan.

This Plan is prohibited from requesting or requiring genetic testing on the part of an individual or his family members. Genetic tests include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or 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.

The Plan may obtain and use the results of a genetic test when making payment determinations (so long as only the minimum amount of information is utilized necessary for the determination).

A plan may request (but not require) that a Participant undergo a genetic test if 1) the plan clearly indicates that compliance is voluntary, and that noncompliance will have no effect on enrollment status or premium/contribution amounts, 2) no Genetic Information collected is used for underwriting purposes, and 3) the plan notify the applicable federal government agency that the plan is conducting activities pursuant to this exception and includes a description of the activities.

Women's Health And Cancer Rights Act

Effective October 21, 1998, the Federal Women's Health and Cancer Rights Act requires all health care plans that provide coverage for a Mastectomy must also provide coverage for the following Medical Care: reconstruction of the breast on which the Mastectomy has been performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and physical complications at all stages of the Mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient. Covered benefits are subject to all provisions described in Your Plan, including but not limited to: Deductible, Copayment, Coinsurance, exclusions, and limitations.

Consolidated Appropriations Act Of 2021 Notice - Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an In-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care Provider, you may owe certain Out-of-Pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a Provider or visit a health care facility that isn't in your health plan's Network.

"Out-of-Network" describes Providers and facilities that haven't signed a contract with your health plan. Out-of-Network Providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than In-Network costs for the same service and might not count toward your annual Out-of-Pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of--Network Provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an In-Network Provider or facility, the most the Provider or facility may bill you is your plan's In-Network cost-sharing amount (such as Copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an In-Network Hospital or Ambulatory Surgical Center
When you get services from an In-Network Hospital or Ambulatory Surgical Center, certain Providers there may be In-Network. In these cases, the most those Providers may bill you is your plan's In-Network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these In-Network facilities, In-Network Providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care In-Network. You can choose a Provider or facility in your plan's Network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the Provider or facility was In-Network). Your health plan will pay In-Network Providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (precertification).

    - Cover emergency services by In-Network Providers.

    - Base what you owe the Provider or facility (cost-sharing) on what it would pay an In-Network Provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or In-Network services toward your deductible and Out-of-Pocket limit.

If you believe you've been wrongly billed, you may contact Health and Human Services (HHS") at (800) 985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.