PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

ARDENT HEALTH SERVICES GROUP HEALTH PLAN

PPO Premier Plan
HDHP

EFFECTIVE DATE: January 1, 2020

RESTATEMENT DATE: January 1, 2026

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GENERAL PLAN INFORMATION

Type of Plan: The Plan is a self-funded employee benefit plan.

Type of Administration: The administration of the Plan is provided through a Third-Party Claims Administrator. Plan benefits may be self-funded through a benefit fund, or a trust established by the Plan Sponsor and self-funded with contributions from Employees and/or the Plan Sponsor. The Plan is not insured.

Name of Plan: Ardent Health Services Group Health Plan

Plan Year Ends: December 31

Employer Tax ID Number: 62-1743438

Group Number: 0070900

Plan Number: 501

Employer Information
AHS MANAGEMENT COMPANY, INC.
340 Seven Springs Way Ste 100
Brentwood, TN 37027
(615) 296-3000

Affiliated Companies
AHS UT HEALTH EAST TEXAS – 62-1743438

Plan Sponsor/Plan Administrator
AHS MANAGEMENT COMPANY, INC.
340 Seven Springs Way Ste 100
Brentwood, TN 37027
(615) 296-3000

Named Fiduciary
AHS MANAGEMENT COMPANY, INC.
340 Seven Springs Way Ste 100
Brentwood, TN 37027
(615) 296-3000

Agent for Service of Legal Process
AHS MANAGEMENT COMPANY, INC.
340 Seven Springs Way Ste 100
Brentwood, TN 37027
(615) 296-3000

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

Claims Administrator
Imagine360 Administrators, LLC
6101 South Broadway Suite 300
Tyler, TX 75703
(844) 573-1905

The Plan Administrator has retained the services of the Claims Administrator to administer Claims under the Plan.

INTRODUCTION

The Plan Sponsor identified in the General Plan Information section sponsors the plan named ARDENT HEALTH SERVICES GROUP HEALTH PLAN ("Plan") for its eligible employees and dependents. This document is intended to serve as the Plan Document (PD) and Summary Plan Description (SPD) required by the Employee Retirement Income Security Act ("ERISA") for Plans subject to ERISA. The Plan Sponsor has contracted with Imagine360 to provide claims processing and other Plan administration services.

It is important that You review this document carefully as it describes Plan benefits and Your rights and responsibilities under the Plan. Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims, or lack of coverage.

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

SCHEDULE OF BENEFITS

All benefits described in this Plan Document are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; charges are reasonable and customary (as defined as an Allowable Charge); and services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Definitions section of this document.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all Covered Medical Services and/or exclusions with specificity. Please contact the Claims Administrator regarding questions about specific supplies, treatments or procedures.

PROVIDER INFORMATION

The Plan incorporates a “Care Coordination” process by Quantum Health which leverages resources including but not limited to Your employer, the Plan and the Third-Party Administrator, Your provider and Your community to help You best navigate the healthcare system. This process includes a staff of Care Coordinators who receive notifications regarding most healthcare services sought by Plan Participants, and coordinate activities and information flow between the providers.

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

Care Coordinators: (888) 295-9299

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

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Network providers have contracted with the Plan to provide services to Plan Participants at pre-negotiated rates for savings. It is the Plan Participant’s choice as to which provider to use.

To access a list of Network Providers, please refer to the Network Provider website and/or toll-free number listed on the **Ardent Health Services Group Health Plan identification card**. Prior to receiving medical care services, the Plan Participant should confirm with the provider that the provider is a participant in this network.

Plan Participants may choose to use any appropriate Physician or other provider, Hospital, Outpatient Surgical Center, imaging Facility, outpatient health care Facility, dialysis clinic and other Facility and Covered Medical Services will be reimbursed as stated in the Medical Benefits Schedule.

If a provider belongs to one of the following Networks, claims for Covered Medical Services will normally be processed in accordance with the **Network Provider** benefit levels that are listed on the Medical Benefits Schedule.

Ardent Network – Tier 1

Access Direct Platinum Network– Tier 2

Access Direct Platinum Network is the primary network for the UT Health East Texas system. This network offers a choice of providers and facilities covering nine counties: Smith, Cherokee, Rusk, Panola, Henderson, Van Zandt, Wood, Camp and Gregg.

Services not available at UT Health East Texas will be covered at Children’s Medical Center or UT Southwestern at the ADP tier of benefits.

Please note the following:

- No coverage will be offered at:
  - CHRISTUS Trinity Mother Frances Health System except for Emergency Services.
  - Baylor Scott & White Texas Spine & Joint except for emergency services and Ear, Note & Throat (ENT) procedures.
  - Northwest Texas Healthcare System (TX), Presbyterian Health Services (NM), Ascension St. John (OK) except for emergency, mental health and alcohol/drug treatment.
  - St. Francis Health System (OK) except for emergency, mental health, alcohol/drug treatment and pediatric services (for members under age 17).
  - Akumin Amarillo/Preferred Imaging (TX).

For all Non-Network providers, the Plan will identify the reasonable cost for the services and supplies through its Claim Review and Audit Program.

Under the following circumstances, Non-Network Provider services will pay at the Network benefit level:

1. In the event a Network Provider refers a Participant to a Non-Network Provider for diagnostic testing, x-rays, laboratory services or anesthesia, then charges of the Non-Network Provider will be paid as though the services were provided by a Network Provider.

Covered Medical Services will be reimbursed based on the Allowable Charge. The Plan Participant may be balance billed by the Non-Network Provider for any amount over the Allowable Charge.

NO SURPRISES ACT (NSA)

For Non-Network Provider charges subject to the No Surprises Act (NSA) (part of the Consolidated Appropriations Act of 2021), the Plan Participant cost-sharing will be the Network benefit level which will be calculated as if the Allowable Charge was the Recognized Amount. Any such cost-sharing amounts will accrue toward the Network Provider deductible and maximum out-of-pocket amount. The NSA prohibits Non-Network Providers from pursuing payment from the Plan Participant for the difference between the Allowable Charge and the Non-Network Provider's billed charge for services, except for any applicable cost-sharing.

Non-Network Provider charges subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Network Provider Facility:
  - Provided the Plan Participant has not provided Notice and Consent (as explained below) to waive the applicability of the NSA;
  - Including the furnishing of equipment/devices, labs, imaging, telehealth, pre-operative and post-operative services regardless of being physically located at the Network Facility; and
- Covered Medical Services for air ambulance services.

Benefit determinations for Non-Network Provider claims subject to the NSA will be made within 30 days of the Claims Administrator's receipt of the claim and if applicable, reimbursement will be submitted directly to the Non-Network Provider.

Notice and Consent. Exceptions to the NSA balance billing protections may apply when the Plan Participant receives non-emergency services (other than Ancillary Services) from a Non-Network Provider and gives written consent to receive those services as Non-Network Provider benefits. Ancillary Services include anesthesiology, pathology, radiology, neonatology, assistant surgeons, hospitalists, intensivists, and items and services related to emergency medicine.

PROVIDER DIRECTORIES

If a Plan Participant seeks care based on incorrect information indicating that the provider was a Network Provider at the time the treatment or service was received, the Plan Participant's cost share will be limited to the Network Provider benefit level if the Plan Participant can provide proof within 30 days that they sought care based on the incorrect

information.

CONTINUING CARE PROVISION

In accordance with the Consolidated Appropriations Act of 2021, when a Plan Participant is receiving treatment from a Network Provider, and that provider's relationship with the Plan is terminated, not renewed, or otherwise ends for any reason (other than the provider's failure to meet applicable quality standards or for fraud), the Plan Participant has rights to elect Continuing Care from the former Network Provider.

The Plan shall notify the Plan Participant in a timely manner that the Network Provider's contractual relationship with the Plan has terminated. If the Plan Participant **elects in writing** to receive Continuing Care, benefits will apply under the same terms and conditions as would have applied had the termination not occurred. This Continuing Care Provision becomes available as of the date of the letter received by the Plan Participant that the former Network Provider is no longer associated with the Plan. The Continuing Care Provision will cease 90 days after that date or when the Plan Participant ceases to receive Continuing Care, whichever occurs first.

Under the Continuing Care Provision, the former Network Provider or former Network Facility must: (1) accept reimbursement from the Plan and any applicable cost sharing from the Plan Participant as payment in full; and (2) continue to adhere to all policies, procedures, and standards of care imposed by the Plan in the same manner as if the Network Provider termination had not occurred.

For purposes of this provision, a "Continuing Care" Plan Participant is:

1. undergoing a course of treatment for a serious and complex condition from a specific Network Provider;
2. undergoing a course of institutional or inpatient care from a specific Network Provider;
3. scheduled to undergo non-elective surgery from a specific Network Provider, including postoperative care;
4. pregnant and undergoing a course of treatment for the Pregnancy from a specific Network Provider; or
5. terminally ill and receiving treatment for such illness from a specific Network Provider.

DEDUCTIBLES/COPAYMENTS/COINSURANCE

A **deductible** is an amount of money that is paid once a Calendar Year per Plan Participant. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Medical Services (except for Covered Medical Services that are not subject to the deductible).

Each January 1st, a new deductible amount is required.

The deductible will apply toward the maximum out-of-pocket amount.

A **copayment** is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

Copayments, including Prescription Drug copayments, will not apply toward the deductible.

Copayments, including Prescription Drug copayments, will apply to the maximum out-of-pocket amount.

Coinsurance is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Medical Benefits Schedule and is payable by the Plan Participant until the maximum out-of-pocket amount as shown in the Medical Benefits Schedule is reached. Coinsurance *does not* apply to the deductible and *does not* include copayment amounts.

Once the Plan has made the applicable benefit payment as shown in the Medical Benefits Schedule, the remaining percentage owed is the Plan Participant's "coinsurance" responsibility.

MAXIMUM OUT-OF-POCKET AMOUNT

Covered Medical Services are payable by the Plan at the percentages shown each Calendar Year until the maximum

out-of-pocket amount shown in the Medical Benefits Schedule is reached. Then, Covered Medical Services Incurred by a Plan Participant will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

When a Family Unit reaches the maximum out-of-pocket amount, Covered Medical Services for that Family Unit will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

MEDICAL BENEFITS SCHEDULE – PPO Premier Plan

PPO Premier Plan	Network Providers		Non-Network Providers
	Ardent Network Tier 1	ADP Network Tier 2	
Claims should be received by the Claims Administrator within 365 days from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied. The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.			
DEDUCTIBLE, PER CALENDAR YEAR			
Per Plan Participant	$200	$600	$2,000
Per Family Unit	$400	$1,200	$4,000
Note: The Network Provider deductible amounts cross-accumulates but does not accumulate with the Non-Network deductible amount. The Non-Network deductible amount does not accumulate to the Network Provider deductible amount.			
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Per Plan Participant	$1,000	$3,000	$4,500
Per Family Unit	$2,000	$6,000	$9,000
Note: The Network Provider maximum out of pocket amounts cross-accumulates but does not accumulate with the Non-Network out of pocket amounts. The Non-Network out of pocket amounts does not accumulate to the Network Provider out of pocket amounts.			
The Plan will pay the designated percentage of Covered Medical Services until maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Medical Services for the rest of the Calendar Year unless stated otherwise.			
The following charges do not apply toward the maximum out-of-pocket amount and are never paid at 100%: • Pre-Service Review Penalties • Amounts over the Allowable Charge • Bariatric Surgery copayment			
The following Providers are not covered under this Plan: • CHRISTUS Trinity Mother Frances Health System except for Emergency Services. • Baylor Scott & White Texas Spine & Joint except for emergency services and Ear, Note & Throat (ENT) procedures. • Northwest Texas Healthcare System (TX), Presbyterian Health Services (NM), Ascension St. John (OK) except for emergency, mental health and alcohol/drug treatment. • St. Francis Health System (OK) except for emergency, mental health, alcohol/drug treatment and pediatric services (for members under age 17). • Akumin Amarillo/Preferred Imaging (TX).			

PPO Premier Plan *For more information about benefits shown below, refer to the Covered Medical Services section.*	**Network Providers**		**Non-Network Providers**
	Ardent Network Tier 1	**ADP Network Tier 2**	
Note: The maximums listed below are the total for Network and Non-Network Provider expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network Providers and Non-Network Provider.			
Ambulance Services			
Land	90% after Tier 1 deductible		
Air	90% after Tier 1 deductible		
Chemotherapy and Radiation Treatment	90% after deductible	80% after deductible	60% after deductible
Wig after chemotherapy or radiation treatment or Alopecia Areata	90% after deductible	80% after deductible	60% after deductible
Wigs are limited to $500 per Calendar Year ***Note:*** *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Diagnostic Testing (X-Rays, Labs and all other diagnostic testing)	100% after $20 copayment per visit, no deductible applies	100% after $40 copayment per visit, no deductible applies	100% after $60 copayment per visit, no deductible applies
Dialysis	90% after deductible Subject to a maximum of 200% of Medicare allowable rate for treatment in the Access Direct Platinum Network	80% after deductible Subject to a maximum of 200% of Medicare allowable rate for treatment in the Access Direct Platinum Network	60% after deductible
Note: *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Durable Medical Equipment, Prosthetics, and Orthotics			
Durable Medical Equipment (DME)	90% after deductible	80% after deductible	60% after deductible
Prosthetics	90% after deductible	80% after deductible	60% after deductible
Orthotics	90% after deductible	80% after deductible	60% after deductible
Note: *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Emergency Room Services			
Facility	100% after $150 copayment per visit, no deductible applies		
Physician	100% no deductible applies		

PPO Premier Plan *For more information about benefits shown below, refer to the Covered Medical Services section.*	**Network Providers**		**Non-Network Providers**
	Ardent Network Tier 1	**ADP Network Tier 2**	
***Note**: Under the No Surprises Act (NSA) (part of the Consolidated Appropriations Act of 2021), Emergency Room Services will include any item or service provided during and after the Emergency Room visit, until such time as the provider determines that the Plan Participant is able to travel using non-medical transportation or non-emergency medical transportation. See "Emergency Services" in the Definitions section of this Plan Document for reference.*			
Hearing Exams, Aids and Services			
Hearing Exams	90% after deductible	80% after deductible	60% after deductible
Hearing Aids and Services	90% after deductible	80% after deductible	60% after deductible
Hearing Aids are limited to $2,500 per Calendar Year.			
Home Health Care	90% after deductible	80% after deductible	60% after deductible
Home Health Care is limited to 100 visits per Calendar Year. ***Note:** Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Home Infusion Therapy	90% after deductible	80% after deductible	60% after deductible
Hospice Care	90% after deductible	80% after deductible	60% after deductible
***Note:** Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Hospital Facility (inpatient)	90% after deductible	80% after deductible	60% after deductible
***Note:** Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Imaging Services (MRI, MRA, CT/PET scans)			
Outpatient Hospital Facility	90% after deductible	80% after deductible	60% after deductible
Freestanding Facility	90% after deductible	80% after deductible	60% after deductible
All outpatient Imaging Services done within Smith County must be done at UT Health. ***Note:** Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Infertility Treatment (other than diagnostic testing)	Not Covered	Not Covered	Not Covered
***Note:** This Plan provides coverage for treatment of the underlying medical condition associated with Infertility. See Covered Medical Services section for more information.*			
Infusion Therapy	90% after deductible	80% after deductible	60% after deductible
Medical Pharmaceuticals	90% after deductible	80% after deductible	60% after deductible
Mental Disorders and Substance Abuse Treatment			
Inpatient Facility	90% after deductible	80% after deductible	60% after deductible

PPO Premier Plan *For more information about benefits shown below, refer to the Covered Medical Services section.*	**Network Providers**		**Non-Network Providers**
	Ardent Network Tier 1	**ADP Network Tier 2**	
Inpatient Physician	100%, no deductible applies	80% after deductible	60% after deductible
Note: *Pre-Service Review for inpatient admissions is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Outpatient Hospital Facility	90% after deductible	80% after deductible	60% after deductible
Outpatient Surgical Center	90% after deductible	80% after deductible	60% after deductible
Outpatient Physician	100%, no deductible applies	80% after deductible	60% after deductible
Note: *Pre-Service Review for outpatient services is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Office Visits	100%, no deductible applies	100% after $15 copayment per visit, no deductible applies	100% after $30 copayment per visit, no deductible applies
Note: The office visit copayment includes exam, allergy injections, allergy serum, labs and x-rays.			
Morbid Obesity	90% after deductible	80% after deductible	60% after deductible
Bariatric Surgery Limited to 1 surgery after 1 year of being eligible and enrolled under the Plan.	100% after deductible and $2,500 copayment per surgery (Copayment does not apply towards the maximum out of pocket amount)	Not Covered	Not Covered
Weight Loss Program	100% after deductible	80% after deductible	60% after deductible
Note: *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Organ Transplants	From a Transplant Facility Partner: 80% after Tier 2 deductible, otherwise 90% after deductible	80% after deductible	From a Transplant Facility Partner: 80% after Tier 2 deductible, otherwise Not Covered
Transportation and Lodging	100%, no deductible applies	80% after deductible	Not Covered
Transportation and Lodging limited to $10,000 per transplant. ***Note:*** *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Outpatient Hospital Facility / Outpatient Surgical Center			
Outpatient Hospital Facility	90% after deductible	80% after deductible	60% after deductible

PPO Premier Plan *For more information about benefits shown below, refer to the Covered Medical Services section.*	**Network Providers**		**Non-Network Providers**
	Ardent Network Tier 1	**ADP Network Tier 2**	
Outpatient Surgical Center	90% after deductible	80% after deductible	60% after deductible
Note: *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Physician Services			
Inpatient services	100%, no deductible applies	80% after deductible	60% after deductible
Note: *Pre-Service Review for inpatient admissions is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Outpatient services	100%, no deductible applies	80% after deductible	60% after deductible
Note: *Pre-Service Review for outpatient services is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Office Visits Primary Care Physician	100%, no deductible applies	100% after $15 copayment per visit, no deductible applies	100% after $30 copayment per visit, no deductible applies
Specialist	100%, no deductible applies	100% after $30 copayment per visit, no deductible applies	100% after $50 copayment per visit, no deductible applies
Note: The office visit copayment includes exam, allergy injections, allergy serum, labs and x-rays.			
"Primary Care Physician" shall mean a general practitioner, family practitioner, general internist, obstetrician / gynecologist, pediatrician, Nurse Practitioner (N.P.), Physician's Assistant (P.A.), licensed professional counselor, licensed certified professional counselor, certified chemical dependency counselor, or licensed clinical social worker.			
Surgery (including surgery in the office)	100%, no deductible applies	80% after deductible	60% after deductible
Pregnancy	90% after deductible	80% after deductible	60% after deductible
Routine prenatal office visits	100%, no deductible applies *If global maternity fee:* 40% of Covered Medical Services will be payable at 100%, no deductible applies; thereafter 90% after deductible	100%, no deductible applies *If global maternity fee:* 40% of Covered Medical Services will be payable at 100%, no deductible applies; thereafter 80% after deductible	60% after deductible
Note: *Pre-Service Review for maternity admissions that exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery is required to avoid a penalty. See the Utilization Management section for more information. Refer to the Pregnancy benefit listed in the Covered Medical Services section for more information regarding routine prenatal office visits.*			

PPO Premier Plan *For more information about benefits shown below, refer to the Covered Medical Services section.*	Network Providers		Non-Network Providers
	Ardent Network Tier 1	**ADP Network Tier 2**	
Preventive Care			
Routine Well Care (birth through adult)	100%, no deductible applies	100%, no deductible applies	100%, no deductible applies

Benefits for Routine Well Care Services, Routine Well Child Services, and Women's Preventive Services as determined by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations, and other sources such as Health Resources and Services Administration (HRSA), and Healthcare.gov, are available to Plan Participants.

All services identified through these resources include age and developmentally appropriate frequency recommendations and other criteria for the purpose of disease identification and prevention.

Routine Well Care Services include, but are not limited to, routine physical exams, screenings, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and disease prevention, education, and intervention.

Routine Well Child Services promote periodic routine examinations and immunizations, newborn vision and hearing screenings, early identification and intervention of nutritional or behavioral concerns, and ongoing preventive education.

Recommendations specific to **Women's Preventive Services** include but are not limited to routine office/well-woman visits, routine pre-natal care, breastfeeding support and supplies, contraception, sterilization procedures, screening and/or counseling as related to: breast cancer, cervical cancer, sexually transmitted disease, interpersonal and domestic violence, reproduction/pregnancy, and gestational diabetes.

The USPSTF in further support of the Affordable Care Act (ACA), also identifies in their Preventive Care recommendations the importance of disease prevention and encourage medical professionals screen for and identify lifestyles and behaviors where education, behavior intervention, and/or counseling would be beneficial. Intervention is recommended through the promotion of diabetic education, nutritional education counseling, obesity prevention and behavioral interventions, and tobacco/nicotine addiction prevention and cessation counseling, as a few examples.

For a complete up-to-date list of current Preventive Care recommendations, access:

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
https://www.healthcare.gov/coverage/preventive-care-benefits;
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
and http://www.hrsa.gov/womens-guidelines

PPO Premier Plan *For more information about benefits shown below, refer to the Covered Medical Services section.*	Network Providers		Non-Network Providers
	Ardent Network Tier 1	ADP Network Tier 2	
Expanded Preventive List For Specific Chronic Conditions	100%, no deductible applies	100%, no deductible applies	100%, no deductible applies
These specified services and items are treated as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition specified below, and only when prescribed for the purpose of preventing the exacerbation of the chronic condition or the development of a secondary condition. If an individual is diagnosed with more than one chronic condition, all listed services and items applicable to the two or more conditions are preventive care. However, services and items not listed below that are for secondary conditions or complications that occur notwithstanding the preventive care are not treated as preventive care.			
Preventive Care for Specified Conditions	**For Individuals Diagnosed with**		
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease		
Anti-resorptive therapy	Osteoporosis and/or osteopenia		
Beta-blockers	Congestive heart failure and/or coronary artery disease		
Blood pressure monitor	Hypertension		
Inhaled corticosteroids	Asthma		
Insulin and other glucose lowering agents	Diabetes		
Retinopathy screening	Diabetes		
Peak flow meter	Asthma		
Glucometer	Diabetes		
Hemoglobin A1C testing	Diabetes		
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders		
Low-density Lipoprotein (LDL) testing	Heart disease		
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression		
Statins	Heart disease and/or diabetes		
Rehabilitation Services			
Inpatient	90% after deductible	80% after deductible	60% after deductible
Inpatient Rehabilitation Services are limited to 60 days, combined with Skilled Nursing Facilities visit limits.			
Note: *Pre-Service Review for inpatient admissions is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Outpatient - Physical Therapy	100% after $20 copayment per visit, no deductible applies	100% after $30 copayment per visit, no deductible applies	100% after $40 copayment per visit, no deductible applies
Outpatient - Occupational Therapy	100% after $20 copayment per visit, no deductible applies	100% after $30 copayment per visit, no deductible applies	100% after $40 copayment per visit, no deductible applies

PPO Premier Plan *For more information about benefits shown below, refer to the Covered Medical Services section.*	**Network Providers**		**Non-Network Providers**
	Ardent Network Tier 1	**ADP Network Tier 2**	
Outpatient - Speech Therapy	100% after $20 copayment per visit, no deductible applies	100% after $30 copayment per visit, no deductible applies	100% after $40 copayment per visit, no deductible applies
Outpatient – Cardiac Rehabilitation	100% after $20 copayment per visit, no deductible applies	100% after $30 copayment per visit, no deductible applies	100% after $40 copayment per visit, no deductible applies
Outpatient - All Other	90% after deductible	80% after deductible	60% after deductible
Occupational Therapy, Speech Therapy and Physical Therapy is limited to a combined 50 visits per Calendar Year.			
Retail Health Clinic	100% after $15 copayment per visit, no deductible applies	100% after $30 copayment per visit, no deductible applies	100% after $40 copayment per visit, no deductible applies
Retail Health Clinic includes all services provided during the Retail Health Clinic visit.			
Routine Well Newborn Nursery Care (while Hospital confined at birth)	90% after deductible	80% after deductible	60% after deductible
Skilled Nursing Facility	90% after deductible	80% after deductible	60% after deductible
Skilled Nursing Facilities are limited to 60 days per Calendar Year, combined with inpatient Rehabilitation Services visit limits. ***Note:*** *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Spinal Manipulation / Chiropractic Care	100% after $20 copayment per visit, no deductible applies	100% after $30 copayment per visit, no deductible applies	100% after $40 copayment per visit, no deductible applies
Spinal Manipulation / Chiropractic Care is limited to 20 visits per Calendar Year. ***Note:*** *Diagnostic labs and x-rays related to Chiropractic Care are payable under the separate Diagnostic Testing benefit.*			
Urgent Care Services	100%, no deductible applies	100% after $30 copayment per visit, no deductible applies	100% after $40 copayment per visit, no deductible applies
Urgent Care services include all services provided during the Urgent Care visit.			
All Other Covered Medical Services	90% after deductible	80% after deductible	60% after deductible

PRESCRIPTION DRUG BENEFITS SCHEDULE – Premier PPO Plan

Administered by **EmpiRX**

The medical deductible does not apply to Prescription Drugs.

Prescription Drug copayments apply towards the Tier 2 maximum out of pocket amount.

Participating Retail Pharmacy – *per 30-day supply per prescription*

Preventive Drugs	$0 copayment per prescription
Generic drugs	$10 copayment per prescription
Preferred Brand Name drugs	20% (up to $50) copayment per prescription
Non-Preferred Brand Name drugs	30% (up to $150) copayment per prescription

Mail Order Pharmacy – *available up to a 90-day supply per prescription*

Generic drugs	$20 copayment per prescription
Preferred Brand Name drugs	20% (up to $100) copayment per prescription
Non-Preferred Brand Name drugs	30% (up to $300) copayment per prescription

Specialty Drugs – *limited up to a 30-day supply per prescription.*

Specialty drugs	30% (up to $200) copayment per prescription

Additional information regarding the Prescription Drug Benefit may be found in the separate Prescription Drug Benefits section of this document.

MEDICAL BENEFITS SCHEDULE – HDHP
This Plan is intended to be a qualifying High Deductible Health Plan (HDHP).

HIGH DEDUCTIBLE HEALTH PLAN

A qualified High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) provides coverage for high-cost medical events, in a tax-advantaged way, to help build savings for future medical expenses. The Plan gives a covered Employee greater control over how health care benefits are used. An HDHP satisfies certain statutory requirements with respect to minimum deductibles and maximum out-of-pocket expenses for single and family coverage. These minimum deductibles and limits for out-of-pocket expenses are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

Only those Employees covered under a qualified HDHP are eligible to contribute to an HSA.

If a Plan Participant has coverage under this Plan and another plan, the other plan would also need to be a qualified HDHP in order for the Plan Participant to contribute to an HSA.

HDHP	**Network Providers**		**Non-Network Providers**
	Ardent Network Tier 1	**ADP Network Tier 2**	
Claims should be received by the Claims Administrator within 365 days from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied. The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.			
DEDUCTIBLE, PER CALENDAR YEAR			
Employee Only Coverage	$1,700	$3,000	$4,000
Family Coverage (Employee + 1 or more)	$3,400	$6,000	$8,000
Non-Embedded Deductible This Plan has a "**non-embedded deductible"** which means: **Employee Only Coverage:** Covered Employees **without** covered Dependents must meet the Employee Only Coverage deductible amount. **Family Coverage:** Covered Employees **with** covered Dependents must meet the Family Coverage deductible amount, without regard to which covered family member Incurred the expenses.			
Note: The Network Provider deductible amounts cross-accumulates but does not accumulate with the Non-Network deductible amount. The Non-Network deductible amount does not accumulate to the Network Provider deductible amount.			

HDHP	Network Providers		Non-Network Providers
	Ardent Network Tier 1	ADP Network Tier 2	
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Per Plan Participant	$3,000	$5,000	$6,500
Per Family Unit	$6,000	$10,000	$13,000
Embedded Maximum Out-of-Pocket Amount: This Plan has an "embedded" maximum out of pocket amount which means a covered family member only needs to satisfy his or her individual maximum out of pocket amount, not the entire family maximum out of pocket amount. However, the maximum out of pocket amount for all members of that Family Unit will only be satisfied when the family maximum out of pocket amount has been met for that Calendar Year.			
Note: The Network Provider maximum out of pocket amounts cross-accumulates but does not accumulate with the Non-Network out of pocket amounts. The Non-Network out of pocket amounts does not accumulate to the Network Provider out of pocket amounts.			
The Plan will pay the designated percentage of Covered Medical Services until maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Medical Services for the rest of the Calendar Year unless stated otherwise.			
The following charges do not apply toward the maximum out-of-pocket amount and are never paid at 100%: • Pre-Service Review Penalties • Amounts over the Allowable Charge • Bariatric Surgery copayment			

HDHP *For more information about benefits shown below, refer to the Covered Medical Services section.*	Network Providers		Non-Network Providers
	Ardent Network Tier 1	ADP Network Tier 2	
Note: The maximums listed below are the total for Network and Non-Network Provider expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network Providers and Non-Network Provider.			
Ambulance Services			
Land	80% after Tier 1 deductible		
Air	80% after Tier 1 deductible		
Chemotherapy and Radiation Treatment	80% after deductible	70% after deductible	60% after deductible
Wig after chemotherapy or radiation treatment or Alopecia Areata	80% after deductible	70% after deductible	60% after deductible
Wigs are limited to $500 per Calendar Year ***Note:*** *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			

HDHP *For more information about benefits shown below, refer to the Covered Medical Services section.*	**Network Providers**		**Non-Network Providers**
	Ardent Network Tier 1	**ADP Network Tier 2**	
Diagnostic Testing (X-Rays, Labs and all other diagnostic testing)	80% after deductible	70% after deductible	60% after deductible
Dialysis	80% after deductible Subject to a maximum of 200% of Medicare allowable rate for treatment in the Access Direct Platinum Network	70% after deductible Subject to a maximum of 200% of Medicare allowable rate for treatment in the Access Direct Platinum Network	60% after deductible
Note: *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Durable Medical Equipment, Prosthetics, and Orthotics			
Durable Medical Equipment (DME)	80% after deductible	70% after deductible	60% after deductible
Prosthetics	80% after deductible	70% after deductible	60% after deductible
Orthotics	80% after deductible	70% after deductible	60% after deductible
Note: *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Emergency Room Services			
Facility	80% after Tier 1 deductible		
Physician	80% after Tier 1 deductible		
Note*: Under the No Surprises Act (NSA) (part of the Consolidated Appropriations Act of 2021), Emergency Room Services will include any item or service provided during <u>and after</u> the Emergency Room visit, until such time as the provider determines that the Plan Participant is able to travel using non-medical transportation or non-emergency medical transportation. See "Emergency Services" in the Definitions section of this Plan Document for reference.*			
Hearing Exams, Aids and Services			
Hearing Exams	80% after deductible	70% after deductible	60% after deductible
Hearing Aids and Services	80% after deductible	70% after deductible	60% after deductible
Hearing Aids are limited to $2,500 per Calendar Year.			
Home Health Care	80% after deductible	70% after deductible	60% after deductible
Home Health Care is limited to 100 visits per Calendar Year. ***Note:*** *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Home Infusion Therapy	80% after deductible	70% after deductible	60% after deductible
Hospice Care	80% after deductible	70% after deductible	60% after deductible

HDHP *For more information about benefits shown below, refer to the Covered Medical Services section.*	**Network Providers**		**Non-Network Providers**
	Ardent Network Tier 1	**ADP Network Tier 2**	
***Note:** Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Hospital Facility (inpatient)	80% after deductible	70% after deductible	60% after deductible
***Note:** Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Imaging Services (MRI, MRA, CT/PET scans)			
Outpatient Hospital Facility	80% after deductible	70% after deductible	60% after deductible
Freestanding Facility	80% after deductible	70% after deductible	60% after deductible
All outpatient Imaging Services done within Smith County must be done at UT Health. ***Note:** Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Infertility Treatment (other than diagnostic testing)	Not Covered	Not Covered	Not Covered
***Note:** This Plan provides coverage for treatment of the underlying medical condition associated with Infertility. See Covered Medical Services section for more information.*			
Infusion Therapy	80% after deductible	70% after deductible	60% after deductible
Medical Pharmaceuticals	80% after deductible	70% after deductible	60% after deductible
Mental Disorders and Substance Abuse Treatment			
Inpatient Facility	80% after deductible	70% after deductible	60% after deductible
Inpatient Physician	80% after deductible	70% after deductible	60% after deductible
***Note:** Pre-Service Review for inpatient admissions is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Outpatient Hospital Facility	80% after deductible	70% after deductible	60% after deductible
Outpatient Surgical Center	80% after deductible	70% after deductible	60% after deductible
Outpatient Physician	80% after deductible	70% after deductible	60% after deductible
***Note:** Pre-Service Review for outpatient services is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Office Visits	80% after deductible	70% after deductible	60% after deductible

HDHP *For more information about benefits shown below, refer to the Covered Medical Services section.*	Network Providers		Non-Network Providers
	Ardent Network Tier 1	**ADP Network Tier 2**	
Morbid Obesity	80% after deductible	70% after deductible	60% after deductible
Bariatric Surgery Limited to 1 surgery after 1 year of being eligible and enrolled under the Plan.	100% after deductible and $2,500 copayment per surgery (Copayment does not apply towards the maximum out of pocket amount)	Not Covered	Not Covered
Weight Loss Program	80% after deductible	70% after deductible	60% after deductible
Note: *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Organ Transplants	From a Transplant Facility Partner: 70% after Tier 2 deductible, otherwise 80% after deductible	70% after deductible	From a Transplant Facility Partner: 70% after Tier 2 deductible, otherwise Not Covered
Transportation and Lodging	80% after deductible	70% after deductible	Not Covered
Transportation and Lodging limited to $10,000 per transplant. ***Note:*** *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Outpatient Hospital Facility / Outpatient Surgical Center			
Outpatient Hospital Facility	80% after deductible	70% after deductible	60% after deductible
Outpatient Surgical Center	80% after deductible	70% after deductible	60% after deductible
Note: *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Physician Services			
Inpatient services	80% after deductible	70% after deductible	60% after deductible
Note: *Pre-Service Review for inpatient admissions is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Outpatient services	80% after deductible	70% after deductible	60% after deductible
Note: *Pre-Service Review for outpatient services is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Office Visits	80% after deductible	70% after deductible	60% after deductible
"Primary Care Physician" shall mean a general practitioner, family practitioner, general internist, obstetrician / gynecologist, pediatrician, Nurse Practitioner (N.P.), Physician's Assistant (P.A.), licensed professional counselor, licensed certified professional counselor, certified chemical dependency counselor, or licensed clinical social worker.			

HDHP *For more information about benefits shown below, refer to the Covered Medical Services section.*	**Network Providers**		**Non-Network Providers**
	Ardent Network Tier 1	**ADP Network Tier 2**	
Surgery (including surgery in the office)	80% after deductible	70% after deductible	60% after deductible
Pregnancy	80% after deductible	70% after deductible	60% after deductible
Routine prenatal office visits	100%, no deductible applies *If global maternity fee:* 40% of Covered Medical Services will be payable at 100%, no deductible applies; thereafter 80% after deductible	100%, no deductible applies *If global maternity fee:* 40% of Covered Medical Services will be payable at 100%, no deductible applies; thereafter 70% after deductible	60% after deductible
Note: *Pre-Service Review for maternity admissions that exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery is required to avoid a penalty. See the Utilization Management section for more information. Refer to the Pregnancy benefit listed in the Covered Medical Services section for more information regarding routine prenatal office visits.*			
Preventive Care			
Routine Well Care (birth through adult)	100%, no deductible applies	100%, no deductible applies	100%, no deductible applies

HDHP *For more information about benefits shown below, refer to the Covered Medical Services section.*	Network Providers		Non-Network Providers
	Ardent Network Tier 1	ADP Network Tier 2	

Benefits for Routine Well Care Services, Routine Well Child Services, and Women's Preventive Services as determined by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations, and other sources such as Health Resources and Services Administration (HRSA), and Healthcare.gov, are available to Plan Participants.

All services identified through these resources include age and developmentally appropriate frequency recommendations and other criteria for the purpose of disease identification and prevention.

Routine Well Care Services include, but are not limited to, routine physical exams, screenings, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and disease prevention, education, and intervention.

Routine Well Child Services promote periodic routine examinations and immunizations, newborn vision and hearing screenings, early identification and intervention of nutritional or behavioral concerns, and ongoing preventive education.

Recommendations specific to **Women's Preventive Services** include but are not limited to routine office/well-woman visits, routine pre-natal care, breastfeeding support and supplies, contraception, sterilization procedures, screening and/or counseling as related to: breast cancer, cervical cancer, sexually transmitted disease, interpersonal and domestic violence, reproduction/pregnancy, and gestational diabetes.

The USPSTF in further support of the Affordable Care Act (ACA), also identifies in their Preventive Care recommendations the importance of disease prevention and encourage medical professionals screen for and identify lifestyles and behaviors where education, behavior intervention, and/or counseling would be beneficial. Intervention is recommended through the promotion of diabetic education, nutritional education counseling, obesity prevention and behavioral interventions, and tobacco/nicotine addiction prevention and cessation counseling, as a few examples.

For a complete up-to-date list of current Preventive Care recommendations, access:

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
https://www.healthcare.gov/coverage/preventive-care-benefits;
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
and http://www.hrsa.gov/womens-guidelines

HDHP *For more information about benefits shown below, refer to the Covered Medical Services section.*	Network Providers		Non-Network Providers
	Ardent Network Tier 1	**ADP Network Tier 2**	
Expanded Preventive List For Specific Chronic Conditions	100%, no deductible applies	100%, no deductible applies	100%, no deductible applies

These specified services and items are treated as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition specified below, and only when prescribed for the purpose of preventing the exacerbation of the chronic condition or the development of a secondary condition. If an individual is diagnosed with more than one chronic condition, all listed services and items applicable to the two or more conditions are preventive care. However, services and items not listed below that are for secondary conditions or complications that occur notwithstanding the preventive care are not treated as preventive care.

Preventive Care for Specified Conditions	**For Individuals Diagnosed with**
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1C testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

Rehabilitation Services			
Inpatient	80% after deductible	70% after deductible	60% after deductible
Inpatient Rehabilitation Services are limited to 60 days, combined with Skilled Nursing Facilities visit limits.			
Note: *Pre-Service Review for inpatient admissions is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Outpatient	80% after deductible	70% after deductible	60% after deductible
Occupational Therapy, Speech Therapy and Physical Therapy is limited to a combined 50 visits per Calendar Year.			
Retail Health Clinic	80% after deductible	70% after deductible	60% after deductible
Retail Health Clinic includes all services provided during the Retail Health Clinic visit.			

HDHP *For more information about benefits shown below, refer to the Covered Medical Services section.*	**Network Providers**		**Non-Network Providers**
	Ardent Network Tier 1	**ADP Network Tier 2**	
Routine Well Newborn Nursery Care (while Hospital confined at birth)	80% after deductible	70% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible	70% after deductible	60% after deductible
Skilled Nursing Facilities are limited to 60 days per Calendar Year, combined with inpatient Rehabilitation Services visit limits. ***Note:*** *Pre-Service Review is required to prevent a penalty. Please refer to the Utilization Management section for more information.*			
Spinal Manipulation / Chiropractic Care	80% after deductible	70% after deductible	60% after deductible
Spinal Manipulation / Chiropractic Care is limited to 20 visits per Calendar Year. ***Note:*** *Diagnostic labs and x-rays related to Chiropractic Care are payable under the separate Diagnostic Testing benefit.*			
Urgent Care Services	80% after deductible	70% after deductible	60% after deductible
Urgent Care services include all services provided during the Urgent Care visit.			
All Other Covered Medical Services	80% after deductible	70% after deductible	60% after deductible

PRESCRIPTION DRUG BENEFITS SCHEDULE – HDHP

Administered by **EmpiRX**

Prescription Drug cost-share applies after the medical deductible has been met.

Prescription Drug copayments apply towards the Tier 2 maximum out of pocket amount.

Participating Retail Pharmacy – *per 30-day supply per prescription*

Preventive Drugs	$0 copayment per prescription, no deductible applies
Generic drugs	20% copayment after deductible per prescription
Preferred Brand Name drugs	20% copayment after deductible per prescription
Non-Preferred Brand Name drugs	20% copayment after deductible per prescription

Mail Order Pharmacy – *available up to a 90-day supply per prescription*

Generic drugs	20% copayment after deductible per prescription
Preferred Brand Name drugs	20% copayment after deductible per prescription
Non-Preferred Brand Name drugs	20% copayment after deductible per prescription

Specialty Drugs – *limited up to a 30-day supply per prescription.*

Specialty drugs	20% copayment after deductible per prescription

Additional information regarding the Prescription Drug Benefit may be found in the separate Prescription Drug Benefits section of this document.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Classes of Employees.

All Active Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage if he or she:

1. Is a full-time, Active Employee of the Employer. An Employee is considered to be full-time if the Employee is regularly scheduled to work at least 20 hours per week and is on the regular payroll of the Employer for that work.

2. Completes the employment waiting period of 30 consecutive days as an Active Employee

   If an Employee changes from a non-qualifying or part-time position to a qualifying or full-time or Active Employee position as defined under this Plan, the Employee will be credited with time worked in the non-qualifying or part-time position toward the employment Waiting Period.
3. Is in an eligible class.

Eligible Classes of Dependents. A "**Dependent**" is any one of the following persons:

1. A covered **Employee's Spouse.**

   The term "**Spouse**" shall mean the person to whom the covered Employee is legally married.

   Spouses who are eligible *(regardless of enrollment)* for their own employer-sponsored health coverage are not eligible for coverage under this Plan.

   The Plan Administrator may require documentation proving a legal marriage.

   The term "Spouse" will also include "**Domestic Partner**" which shall mean a covered Employee's partner with whom a Domestic Partnership has been established, and any Employer required documentation has been received and accepted by the Employer.

2. A covered **Employee's Dependent child(ren).**

   A covered Employee's/ "**Dependent child**" includes natural child, Stepchild, adopted child, Domestic Partner's natural child, a child placed with the covered Employee in anticipation of adoption, or children for whom the Employee or covered Spouse is Legal Guardian. A Dependent child will be eligible until reaching the limiting age of 26.

   A "**Stepchild**" means a child of the Spouse who meets the eligibility requirements of this Plan for whom a covered Employee is the stepparent of the child(ren).

   "**Legal Guardian**" means the covered Employee or covered Spouse recognized by a court of law as having the duty of taking care of and managing the property and rights of a minor child.

   The phrase "**child placed with a covered Employee in anticipation of adoption**" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention

by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process has been initiated.

A child of a covered Employee who is an alternate recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Please be advised, the definition of "Dependent" may not be the same definition as established by the Internal Revenue Code (IRC) for individuals that the covered Employee is permitted to pay qualified medical expenses from a Health Savings Account (HSA), or individuals that can be enrolled as an eligible Dependent for tax-free benefits (i.e., non-IRC Section 152 dependent). There may be tax implications for the Employee if he or she enrolls certain eligible Dependent(s). The Employee should consult his or her tax advisor with any questions on the tax consequences of benefits for his or her eligible Dependent(s).

The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

3. A **covered Dependent child who reaches the limiting age** and is 1) incapable of self-sustaining employment by reason of mental or physical handicap, 2) primarily dependent upon the covered Employee for support and maintenance, can continue coverage under this Plan beyond the limiting age of 26. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof that the child is still Your dependent and qualifies for this coverage extension.

   After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: Other individuals living in the covered Employee's home, but who are not eligible as defined above; the divorced former Spouse of the Employee, former Domestic Partner of the Employee, grandchild(ren), foster child(ren),

If a Plan Participant covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the Plan Participant is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both parents are Employees, their children may be covered as Dependent children of one of the parents, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

Please note that the Employee is solely responsible to notify the Plan when their dependent no longer qualifies as an eligible dependent for coverage under the Plan. Failure to timely notify the Plan may result in such Dependent's coverage being retroactively or prospectively terminated and a loss of Your Dependent's right to elect COBRA continuation coverage.

ACQUISITIONS

Employees who were enrolled under the health plan of an acquired company or who were in the eligibility waiting period as of the day before the date of acquisition, if applicable, as of the day before the date of acquisition, will be

eligible to enroll themselves and their previously enrolled eligible Dependents for coverage under this Plan as of the date of acquisition, on the date of termination of the acquired company's benefit plan, or upon satisfaction of the eligibility waiting period, whichever is later. Any deductibles and maximum out-of-pocket amounts previously satisfied under the prior health plan will not be applied toward the coverage under this Plan.

An acquired Employee (and their Dependents) who was not actively enrolled under the health plan offered by the acquired company, but who otherwise meet the eligibility requirements of this Plan, will be eligible to enroll themselves and their eligible Dependents as of the date of acquisition, subject to the eligibility waiting period.

In the event that an acquired company did not have a health plan, all acquired Employees who otherwise meet the eligibility requirements of this Plan (and their eligible Dependents), will be eligible to enroll as of the date of the acquisition, subject to the eligibility waiting period.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the first month following or coinciding with the date that the Employee satisfies all of the following:

1. The Eligibility Requirement.

2. The Active Employee Requirement.

3. The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by completing an enrollment application along with the appropriate payroll deduction authorization, if applicable. If Dependent coverage is desired, the covered Employee will be required to enroll the Dependent(s).

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee must be enrolled in the Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, for there to be coverage for the newborn from the date of birth.

TIMELY OR LATE ENROLLMENT AND OPEN ENROLLMENT

1. **Timely Enrollment** – The enrollment will be "timely" if the request for enrollment is received by the Plan Administrator no later *than the following*:

   a. 31 days after the person *initially* becomes eligible for the coverage; or

   b. 31 days after the person becomes eligible for the coverage under a "Loss of Other Coverage Special Enrollment Period"; or

   c. 31 days after the person becomes eligible for the coverage under a "Acquiring a New Dependent Special Enrollment Period".

   If two Employees are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

2. **Late Enrollment** – An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their eligible Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

   Unless otherwise required by law, if an individual loses eligibility for coverage as a result of terminating employment, reduction of hours of employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

   The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period. Coverage begins as stated in the Open Enrollment section below.

3. **Open Enrollment** – Each year there is an annual open enrollment period designated by the Employer during which eligible Employees may enroll themselves and any eligible Dependents under the Plan or covered Employees may change their and their covered Dependents' benefit elections under the Plan.

   Benefit choices made during the open enrollment period will become effective January 1st.

   Plan Participants will receive detailed information regarding open enrollment from their Employer.

SPECIAL ENROLLMENT PERIODS

Federal law provides Special Enrollment provisions under some circumstances. The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

To request Special Enrollment or obtain more detailed information of these portability rules, contact the Plan Administrator.

1. **Losing other coverage may create a Special Enrollment right.** If an Employee is declining enrollment for themselves or their dependents because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

   An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and the loss of eligibility for coverage meets all of the following conditions:

   a. The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual; and

   b. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment; and

   c. Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as the result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated; and

   d. The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. If the request is timely made, coverage will begin the day following the date of the loss.

      For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

i. The Employee or Dependent has a loss of eligibility due to the other plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).

ii. The Employee or Dependent has a loss of eligibility under the other plan as a result of legal separation, divorce, termination of domestic partnership, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

iii. The Employee or Dependent has a loss of eligibility when the other coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

iv. The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

2. Acquiring a newly eligible Dependent may create a Special Enrollment right, if:

a. The Employee is a Participant under this Plan (or the Employee is eligible, but not enrolled in this Plan), and

b. A person becomes a Dependent of the Employee through marriage, domestic partnership, birth, adoption, or placement for adoption,

then the Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for their eligible Dependents to enroll.

The Special Enrollment Period for newly eligible Dependents is a period of 31 days that begins after the date of the marriage, registration of domestic partnership, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this period.

In the case of birth, adoption, or placement for adoption, marriage and domestic partnerships, the Dependents of the covered Employee may also be enrolled as a Dependent of the covered Employee if the Dependent is otherwise eligible for coverage.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

a. in the case of marriage or domestic partnership, as of the date of marriage or registration of domestic partnership; or

b. in the case of a Dependent's birth, as of the date of birth; or

c. in the case of a Dependent's adoption or placement for adoption, as of the date of the adoption or placement for adoption; or

d. In the case of a Legal Guardianship, as of the date of Legal Guardianship appointment.

3. Medicaid or Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Employees and their Dependents who are otherwise eligible for coverage under the Plan, but who are not enrolled, can enroll in the Plan provided they request enrollment in writing within 60 days from the date of the following loss of coverage or gain in eligibility if:

a. The Employee or Dependent cease to be eligible for Medicaid or a state Children's Health Insurance Program (CHIP) coverage; or

b. The Employee or Dependent become newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Employee and/or Dependent may enroll under this Plan. If the Employee is not enrolled at the time of the event, he or she must enroll under this Special Enrollment Period in order for their eligible Dependent to enroll.

This Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan or on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. The effective date of coverage will be the first day of the first month following the date of loss of coverage or gain in eligibility.

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the Employer, and its Employees.

For more information regarding special enrollment periods, contact the Plan Administrator.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. **If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.** The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to recoup Plan payments by any method allowed by law.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

1. The date the Plan is terminated or amended such that the covered Employee loses coverage;

2. The last day of the month in which the covered Employee ceases to be in one of the Eligible Classes, or, if applicable, the last day of the stability period for which the covered Employee met the required minimum hours of service established by the Employer. This includes death or termination of active employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability or leave of absence, unless the Plan specifically provides for continuation during these periods;

3. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or

4. As otherwise specified in the Eligibility section.

Note: Except in certain circumstances, a covered Employee may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

Rehiring a Terminated Employee. A covered Employee who was terminated and rehired prior to the end of a 13-consecutive week period after the date of termination will be credited with time met towards the employment waiting period, if applicable, as of the date of termination. Coverage will begin the date of rehire. Otherwise, a terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

An exception applies for a terminated Employee on COBRA who is rehired and returns to work after expiration of the above reinstatement period. Coverage will be continuous from the first day of the first month following the date he/she resumes employment with no Waiting Period applied.

Continuation During Periods of Employer CertifiedLeave of Absence, Employer-Certified Disability. Benefits for a covered Employee (and enrolled Dependents) may be continued for a limited period of time if the Active Employee's work ceases due to a qualified leave under this provision. The length and availability of continuation depends on the Employer's leave policies.

If the Employee's leave qualifies under the Family and Medical Leave Act (FMLA), as described below, any continuation of coverage provided under this provision will run concurrent with the FMLA leave.

Coverage under this provision will continue in accordance with the same terms and conditions of an Active Employee. If a COBRA qualifying event occurs, any period of continued coverage under this section will not reduce the maximum time for which the Employee may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

Continuation During Family and Medical Leave. When applicable, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor and amended from time to time, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations. This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and its Employees covered by this Plan. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other applicable State leave law, the Employer 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.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and their covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminated.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

1. The maximum period of coverage of a person under such an election shall be the lesser of:

    a. The 24-month period beginning on the date on which the person's absence begins; or

    b. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

2. A person who elects to continue group health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

3. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA Continuation Coverage requirements. Coverage elected under USERRA runs concurrently with COBRA. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

The Civilian Reservist Emergency Workforce Act of 2021 (“CREW”) provides eligible Employees, who are called to services by the Federal Emergency Management Agency (FEMA), rights under USERRA.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

1. The date the Plan or Dependent coverage under the Plan is terminated;

2. The date that the Employee's coverage under the Plan terminates. (See the section entitled COBRA Continuation Coverage.);

3. The last day of the month in which a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled COBRA Continuation Coverage.);

4. The last day of the month in which a Dependent child ceases to meet the applicable eligibility requirements. (See the section entitled COBRA Continuation Coverage.);

5. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or

6. As otherwise specified in the Eligibility section.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

QUANTUM HEALTH CARE COORDINATION PROCESS

INTRODUCTION

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

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

Care Coordinators: (888) 295-9299

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

CARE COORDINATION REQUIREMENTS

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

The Care Coordination process generally includes:

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

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

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

Covered Members are encouraged to begin all healthcare events or inquiries with a call or visit to their designated PCP who will guide Covered Members as appropriate. In addition to providing Care Coordination and submitting preauthorization requests, the PCP may also receive notices regarding healthcare services that their designated patients receive under the Plan. This allows the PCP to provide ongoing healthcare guidance.
If you have trouble obtaining access to a PCP, the Care Coordinators will be able to assist you by providing a list of in-network PCPs. Please contact the Care Coordinators by calling:

Care Coordinators: (888) 295-9299

Utilization Management

Preauthorization and Clinical Review

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

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

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

Concurrent Utilization Review

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

Personal Care Guide Management

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

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

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

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

The primary Personal Care Guide nurse will:

• Provide comprehensive benefit education/utilization support
• Drive PCP designation and steerage to in-network providers
• Encourage provider involvement
• Deliver pre-certification assistance
• Perform pre-admission, pre-discharge, and post-discharge engagement
• Coordinate for utilization review and discharge planning
• Identify gaps in care and alleviate clinical, financial, and humanistic barriers
• Coordinate second opinions, drive utilization to other third-party vendor tools, and introduce community resources
• Perform behavioral health screening

Our primary nurse model has three foundational drivers for the changes:

• Humanistic: to help members with acute and chronic needs by assigning a single nurse to the Covered Member and their family as well as a heightened attention to psychosocial issues that can negatively affect health, quality of life and financial outcomes.
• Clinical: identify and prioritize members in need of clinical outreach. Improve adherence to quality measures for preventive health and management of chronic conditions.
• Financial: identify and outreach to members at risk for future high costs while encouraging preventive care and chronic condition management to improve health and reduce costs.

GENERAL PROVISIONS FOR CARE COORDINATION

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

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

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

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

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

"Emergency" Admissions and procedures
Any Inpatient admission or Outpatient procedure that has not been previously scheduled and cannot be delayed

without harming the Covered Member's health is considered an emergency for purposes of the Utilization Management notification.

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

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

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

CLINICAL TRIAL BENEFITS

Clinical Trials (Routine Patient Costs). Benefits are provided to Qualified Individuals for the Routine Patient Costs of items and services furnished in connection with participation in an Approved Clinical Trial. Routine Patient Costs include all items and services consistent with the coverage provided under this Plan that are 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 Plan Participant; or

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If one or more Participating Providers is participating in a clinical trial, the Plan may require that a Qualified Individual participate in the trial through such a Participating Provider if the Provider will accept the individual as a participant in the trial.

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

1. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. A cooperative group or center of any of the entities described in (a) through (d) above or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:

        i. to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
        ii. assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review; or

2. The study or investigation is conducted under an Investigational new Drug application reviewed by the Food and Drug Administration; or

3. The study or investigation is a Drug trial that is exempt from having such an Investigational new Drug application.

A Qualified Individual must meet the following conditions:

1. The individual must be eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition; and

    a. The referring health care professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or
    b. The individual provides medical and scientific information establishing that the individual's participation in

such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

CLAIM REVIEW AND AUDIT PROGRAM

The Plan has arranged with Imagine360 for a program of claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees, and charges for services which are not medically appropriate. Benefits for claims which are selected for review and auditing may be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this program will supersede any other Plan provisions related to application of a usual, customary, or reasonable fee determination.

Medical care providers will be given a fully detailed explanation of any charges that are found to be in excess of Allowable Claim Limits and allowed the rights and privileges to file an appeal of the determination, which are the same rights and privileges accorded to Plan Participants; and, in return, the provider must agree not to bill the Plan Participant for charges which were not covered as a result of the claim review and audit. This will in no way affect the rights of the Plan Participant to file an appeal under the Plan. Please refer to the section, "Internal and External Review Procedures" for additional information regarding Plan Participant and provider appeals.

Any Plan Participant who receives a balance-due billing from a medical care provider for these charges should contact Imagine360 or the Plan Administrator right away for assistance.

The Plan Administrator is identified in the General Plan Information section of this Plan Document and Summary Plan Description. Imagine360 may be contacted at:

Imagine360 Administrators, LLC
1550 Liberty Ridge, Suite 330
Wayne, Pennsylvania 19087
Phone: (610) 321-1030
Fax: (610) 321-1031

The Plan Participant must pay for any normal cost-sharing features of the Plan, such as deductibles, coinsurance and copayments, and any amounts otherwise excluded or limited according to the terms of the Plan.

The success of this program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount of Covered Medical Services that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the provider of service and the Plan Participant. In the event that the Plan Administrator does not receive information adequate for the claim review and audit within the time limits required under applicable regulations, it will be necessary to deny the claim. Should such a denial be necessary, the Plan Participant and/or the provider of service may appeal the denial in accordance with the provisions which may be found in the section, "Internal and External Review Procedures" in this Plan Document and Summary Plan Description.

In the following provisions of the Claim Review and Audit Program, the term "Plan Administrator" shall be deemed to mean Imagine360.

"Allowable Claim Limits" mean the charges for services and supplies, listed and included as Covered Medical Services under the Plan, which are Medically Necessary for the care and treatment of an Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Examples of the determination that a charge is within the Allowable Claim Limit include, but are not limited to, the following guidelines:

1. **Errors, Unbundled and/or Unsubstantiated Charges.** Allowable Claim Limits will not include the following amounts:

   a. Charges identified as improperly coded, duplicated, unbundled and/or for services not performed;

   b. Charges for treating Injuries sustained or Illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator can be attributed to medical errors by the provider;

c. Charges that cannot be identified or understood; and

d. Charges that cannot be verified from audits of medical records.

2. Guidelines. The following guidelines will be used when determining Allowable Claim Limits:

a. Facilities. The Allowable Claim Limit for claims by a Facility, including but not limited to, Hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care Facility, shall be the greater of (I) 112% of the Facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. The Allowable Claim Limit for (I) shall not exceed 250% of the federal non-commercial Medicare allowed amount, except for children's hospitals, which shall not exceed 350% of the federal non-commercial Medicare allowed amount. If insufficient information is available to identify either the Facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.

b. Outpatient Surgical Centers. The Allowable Claim Limit for Outpatient Surgical Centers, including ambulatory surgery centers, which are independent Facilities, shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the Medicare allowed amount, the Allowable Claim Limit for such services shall be to the extent available either the outpatient or inpatient Medicare allowed amount for the service, plus an additional 20%.

c. Professional Providers. The Allowable Claim Limits for professional providers shall be determined using the following:

i. For general medical and primary care claims, the Medicare allowed amount in the geographic area plus an additional 40%;

ii. For specialist medical and surgical care claims, the Medicare allowed amount in the geographic area plus an additional 55%;

iii. For anesthesiologist claims, the Medicare allowed amount in the geographic area plus an additional 100%;

iv. For ambulance and air ambulance claims, the Medicare allowed amount in the geographic area plus an additional 20%; or

v. For other non-Facility claims and supplies (such as, but not limited to, Durable Medical Equipment, laboratory services and supplies, and mid-level providers, etc.), the Medicare allowed amount in the geographic area.

For purposes of determining the proper Allowable Claim Limits for professional providers in categories (i), (ii), (iii), (iv), or (v) above, the Plan Administrator shall determine the applicable category for each claim based on the taxonomy code used by the professional provider for that claim. The Plan Administrator determines in its sole discretion the type of provider for determining Allowable Claim Limits, as detailed above.

While this Plan typically pays professional providers based on the Medicare allowed amounts above, certain services may be reimbursed at 110% of the Medicare allowed amount for the service. These services may include, but are not limited to, routine diagnostic tests, evaluation services, telehealth, and services for ongoing therapy. A full list of services subject to this rule can be found here: www.planlimit.com/prof1. This list will be updated at least annually to reflect the Plan's current plan design.

d. **Directly Contracted Providers.** The Allowable Claim Limits for Directly Contracted Providers shall be the negotiated rate as agreed under the Direct Agreement.

e. **Insufficient Information to Determine Allowable Claim Limit.** In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above as may be applicable, Imagine360 may apply the following guidelines:

i. **General Medical and/or Surgical Services.** The Allowable Claim Limit for any covered service may be calculated based upon industry-standard resources including, but not limited to, published and publicly available fee and cost lists and comparisons, or any combination of such resources that in the opinion of the Plan Administrator results in the determination of a reasonable expense under the Plan.

ii. **Medical and Surgical Supplies, Implants, Devices.** The Allowable Claim Limit for charges for medical and surgical supplies made by a provider may be based upon the invoice price (cost) to the provider, plus an additional 12%. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the Plan Administrator.

iii. **Physician, Medical and Surgical Care, Laboratory, X-ray, and Therapy.** The Allowable Claim Limit for these services may be determined based upon the 60th percentile of Fair Health (FH®) Allowed Benchmarks.

Comparable Services or Supplies. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above, Allowable Claim Limits will be determined considering the most comparable services or supplies based upon comparative severity and/or geographic area to determine the Allowable Claim Limit. The Plan Administrator reserves the right, in its sole discretion, to determine any Allowable Claim Limit amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Plan Participant.

In the event that a determination of Allowable Claim Limit for a claim exceeds the actual charges billed for the services and/or supplies, the actual charges billed for the claim shall be the Allowable Claim Limit.

COVERED MEDICAL SERVICES

Covered Medical Services are Medically Necessary services Incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions, and other provisions of this Plan. A charge is Incurred on the date that the service or supply is performed or furnished. Covered Medical Services must be received from a licensed health care professional acting within the scope of his/her license.

1. **Acupuncture.** The charges for acupuncture treatment.

2. **Augmentation Communication Devices** and related instruction or therapy

3. **Allergy Treatment.** The charges for allergy testing, injections, and serum.

4. **Ambulance.** The charges for Medically Necessary ground or air transportation provided by a licensed ambulance service to or from the nearest medically appropriate Hospital or Skilled Nursing Facility unless the Plan Administrator finds a longer trip was Medically Necessary.

5. **Anesthesia.** The charges for the cost and administration of anesthesia and/or an anesthetic as primary treatment or when related to an otherwise Covered Medical Service.

6. **Applied Behavioral Analysis (ABA) Therapy.** The charges for Applied Behavioral Analysis (ABA) Therapy for the treatment of autism spectrum disorder.

7. **Autism Spectrum Disorder.** The charges for treatment of autism spectrum disorder including services such as evaluation and assessment, ABA Therapy, speech therapy, occupational therapy, physical therapy used to address symptoms of autism spectrum disorder.

8. **Blood or Blood Components.** The charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if the Facility receives replacement blood for which there is no charge to the Plan Participant.

9. **Breast Pumps, Breast Pump Supplies Lactation Support and Counseling.** The charges for breast pumps, breast pump supplies, lactation support, and counseling as required under the Affordable Care Act Women's Preventive Services Guidelines subject to the Preventive Care benefits as shown in the Medical Benefit Schedule.

   Breast Pumps and Breast Pump Supplies. Coverage includes:

   - The rental or purchase of a manual breast pump, or a standard electric breast pump (including a double electric breast pump) during the antenatal, perinatal, and postpartum periods of pregnancy. Access to double electric pumps to optimize breastfeeding, are not predicated on prior failure of a manual pump.

   - The rental of a heavy duty/hospital grade breast pump may be Medically Necessary for the period of time that a newborn is hospitalized, however purchase of these pumps is not a Covered Medical Service.

   - Breastfeeding equipment and supplies including pump replacement parts and maintenance, and breast milk storage supplies to optimize the successful initiation and maintenance of breastfeeding, to continue throughout the duration of breastfeeding.

   - A replacement breast pump for each subsequent pregnancy. Replacement supplies for comfort and convenience (cap, nipple, bottle, lid, locking ring) are typically not covered.

   Note: *Breast pumps and breast pump supplies when purchased through a retail store (for example,*

through Target, Wal-Mart, Walgreens) will be considered payable at the Network Provider benefit level only for the purposes of this benefit. The Claims Administrator will require the following documentation: claim form with proof of purchase to include purchase price and item description.

Lactation support and counseling. Coverage includes:

Inpatient and outpatient comprehensive antenatal, perinatal and postpartum lactation support and counseling for female Plan Participants for the duration of the breastfeeding.

10. Breast Reductions if Medically Necessary.

11. Cardiac Rehabilitation. The charges for cardiac rehabilitation services that are:

a. Rendered under the supervision of a Physician;
b. In connection with a myocardial infarction, coronary occlusion, coronary bypass surgery, or other cardiac condition and initiated within 12 weeks after other treatment for the medical condition ends; and
c. Performed in a Facility whose primary purpose is to provide medical care for an Illness or Injury.

12. Cataract Surgery. The charges for the initial contact lenses or glasses required following cataract surgery.

13. Chemotherapy or radiation treatment with Radioactive Substances. The charges for materials and services of technicians.

14. Colonoscopies. Routine colonoscopies, including polyp removal, as provided consistent with the Affordable Care Act Preventive Services requirement. Treatment plans following a colonoscopy, including a routine colonoscopy, and diagnostic colonoscopies will be payable per normal Plan provisions.

15. Contraceptives. All Food and Drug Administration (FDA) approved contraceptive methods when prescribed by a Physician, including but not limited to intrauterine devices (IUDs) and implants, (including insertion and removal when applicable), injections, and any related Physician and Facility charges including complications. Services will be payable subject to the Preventive Care benefit in the Medical Benefits Schedule.

Refer to the separate Prescription Drug Benefits of this Plan regarding prescription coverage of oral contraceptive medications, devices, transdermals, vaginal contraceptives, implantables and injectables, including Physician-prescribed over the counter (OTC) contraceptives for female Plan Participants.

16. Corneal Transplants. The charges for services and supplies in connection with corneal transplants on the same basis as any other Illness.

17. Dental Expenses and Oral Surgery Procedures. The charges for the following Dental expenses and Oral Surgical procedures:

a. Excision of impacted or partially impacted teeth;
b. Cutting procedures on gums or mouth tissues needed to treat an Illness or Injury;
c. External incision and drainage of cellulitis;
d. Open or closed reduction of a fracture or dislocation of the jaw;
e. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, or roof and floor of the mouth;
f. Excision of benign bony growths of the jaw and hard palate;
g. Incision of sensory sinuses, salivary glands or ducts; and
h. Medically Necessary treatment or services due to Injury to sound natural teeth. Treatment must be completed within 12 months from the date of the Injury.

Facility charges and general anesthesia for dental and oral surgery procedures are considered as

Covered Medical Services only if Medically Necessary.

Dental services including an evaluation, dental x-rays, extractions/surgical extractions, and anesthesia, to prepare the mouth for medical care and treatment such as radiation therapy to treat cancer or in preparation for organ transplants are considered a Covered Medical Service.

No charge will be covered for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, and preparing the mouth for the fitting, or continued use, of dentures except when coverage is provided under the Dental Benefit.

18. **Diabetic Education.** The charges for inpatient and outpatient self-management training and education for the treatment of diabetes. This benefit is being provided consistent with the Affordable Care Act Preventive Services requirement.

19. **Diagnostic Testing** (labs & x-rays) **/ Imaging Services** (MRI, MRA, CT/PET scans)**.** The charges for diagnostic testing and imaging services including, but not limited to, labs, x-rays, pathological tests and examinations, radiology readings and interpretations.

20. **Dialysis.** The charges for dialysis services including dialysis, Facility services, supplies, and medications provided during treatment. Laboratory testing and Physician visits will be payable per normal Plan provisions.

21. **Durable Medical Equipment (DME). T**he charges for rental or purchase (whichever is most cost-effective) of Durable Medical Equipment prescribed by a Physician and required for therapeutic use.

The least costly alternative will be eligible in the event more than one item of DME is available to meet a Plan Participant's needs. Benefits will be provided for the repair, adjustment, or replacement of purchased Durable Medical Equipment or components, only within a reasonable time period following purchase, subject to the life expectancy of the equipment. Benefits are not available for certain convenience or luxury features that are considered non-standard.

Repair of purchased Durable Medical Equipment item including the replacement of essential accessories such as hoses, tubing, mouth pieces, etc., are Covered Medical Services only when necessary to make the item serviceable and the total estimated repair and replacement costs do not exceed the acquisition cost of the item. Rental charges for a temporary replacement Durable Medical Equipment item are Covered Medical Services up to a maximum of two consecutive months.

The Plan Administrator may require documentation, including but not limited to the make and model number of the Durable Medical Equipment item, the acquisition cost to the provider, and documentation to support Medical Necessity.

22. **Gender Dysphoria/Transition/Reassignment Surgery**. The charges for Gender Dysphoria/ Transition/Reassignment care and treatment as follows:

Gender Transition/Reassignment Hormone Therapy –

a. Legend drugs prescribed by a qualified healthcare professional; and
b. Is Medically Necessary.

Gender Transition/Reassignment Surgery –

a. A signed letter from a qualified mental health professional is submitted attesting to the Plan Participant's gender dysphoria and readiness to undergo surgical treatment and understanding of the treatment; and
b. Is Medically Necessary.

Charges for services including, but not limited to, breast augmentation, breast removal, hysterectomy, oophorectomy, orchiectomy, vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, placement of a testicular prosthesis, placement of an erectile prosthesis, penectomy, vaginoplasty,

labiaplasty, clitoroplasty may be covered when provided as part of the Gender Transition/Reassignment Surgery benefit and Medically Necessary. Facial or body contouring procedures performed solely to improve appearance are not covered under this Plan.

23. **Genetic Testing and Counseling.** The charges for genetic testing when Medically Necessary or as provided consistent with the Affordable Care Act Preventive Services requirement.

24. **Hearing Exam and Hearing Aids and Services.** The charges for a hearing examination and charges for hearing aids.

This Plan includes a benefit that allows Plan Participants to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by EPIC Hearing Healthcare.

This benefit may be accessed under the Plan by calling EPIC at its toll-free number: 1-866-956-5400. Once contacted, one of EPIC's hearing professionals will coordinate the Plan Participant's care and direct him or her to the nearest appropriate provider.

The hearing aid benefit being provided through EPIC consists of discounted hearing aids and related testing and fitting. EPIC discounts may be as much as 50% below manufacturer's suggested retail prices and up to 35% lower than most discount offers. EPIC will require that the Plan Participant pay for his or her hearing aids and other services not covered under the Plan out-of-pocket prior to the delivery of services.

In the event that You have questions or complaints about the hearing aid products or services offered under the Plan, contact EPIC directly at its toll-free number or write to: EPIC Hearing Services, 3191 W. Temple Ave. Ste. 200, Pomona, CA 91768.

25. **Home Health Care.** The charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Illness. The diagnosis, care, and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide, and therapy services is subject to the Home Health Care limit shown in the Medical Benefits Schedule.

This benefit does not include the following:

a. Services and supplies not included in the Home Health Care Plan;
b. Services of a person who is a close relative of the Plan Participant;
c. Services of any social worker unless a designated LCSW;
d. Transportation services;
e. Food or home delivered meals; and
f. Custodial Care and housekeeping.

Note: Home Infusion Therapy is a separate benefit and charges are not considered under Home Health Care.

A home health care visit will be considered a periodic visit by either a nurse or therapist, or four hours of home health aide services.

26. **Home Infusion Therapy.** The charges for intravenous or gastrointestinal (enteral) infusion or intravenous injection of fluids, nutrition or medication furnished in the home setting.

27. **Hospice Care Services and Supplies.** The charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Plan Participant's condition as being terminal, determined that the Plan Participant is not expected to live more than six months and placed the Plan Participant under a Hospice Care Plan.

Respite care is a Covered Medical Service under this Plan.

28. **Hospital Care.** The charges for room and board and medical services and supplies furnished by a Hospital, Outpatient Surgical Center, inpatient Rehabilitation Facilities, or Birthing Center. Covered Medical Services for room and board will be payable as shown in the Medical Benefits Schedule. After 72 observation hours, a confinement will be considered an inpatient confinement.

29. **Infertility.** The charges for the diagnosis of Infertility and treatment of the underlying medical condition associated with Infertility.

30. **Infusion Therapy.** The charges for intravenous infusion or injection of fluids, nutrition or medication, and charges for hyperalimentation or total parenteral nutrition (TPN) for Plan Participants recovering from or preparing for surgery. Covered Medical Services under this benefit include nursing and administrative services.

31. **Medical Pharmaceuticals.** The charges for pharmaceuticals administered under the medical benefits of this Plan, Incurred in an outpatient, office or home setting.

32. **Medical Services Outside the United States**. The charges for medical services Incurred by the Plan Participant traveling outside the United States and its territories provided that:

a. Treatment is a result of a Medical Emergency, and services are Medically Necessary and recognized as usual treatment for that condition;
b. Medical expenses are considered reasonable and usual and customary based on the nearest U.S. geographic location to point of service;
c. Procedures are approved by the AMA;
d. All usual Plan provisions, maximum benefits, exclusions and limitations apply;
e. Expenses must be filed in U.S. dollar amounts;
f. Services must be translated into English; and
g. Benefits may not be assigned to a provider.

33. **Medical Supplies.** The charges for dressings, sutures, trusses, crutches, and other necessary medical supplies. The charges for elastic/surgical stockings when ordered by a Physician will be limited to three pairs per Calendar Year.

34. **Mental Disorders and Substance Abuse.** Covered Medical Services will be payable for care, supplies, and treatment of Mental Disorders and Substance Abuse.

35. **Morbid Obesity.** The charges for Physician's office visits, related diagnostic testing, surgical treatment, including complications, and non-surgical treatment, including dietary counseling.

A written treatment plan by the attending Physician and documentation that all required medical criteria in advance of any surgical treatment has been met will be required.

Repeat surgical procedures or revisions to surgical procedures may be considered under this Plan only if deemed Medically Necessary.

36. **Nutritional Education Counseling.** The charges for Nutritional Education Counseling consistent with the Affordable Care Act Preventive Services requirement. This benefit will not include weight loss medications or nutritional supplements whether or not prescribed by a Physician.

37. **Obesity Interventions.** This benefit is being provided consistent with the Affordable Care Act Preventive Services requirement.

This Plan will not cover gym memberships, or dues for participation in weight loss programs (e.g., Weight Watchers, etc.), whether or not prescribed by a Physician.

38. **Occupational Therapy**. The charges for occupational therapy must be ordered by a Physician, result from an Injury or Illness including autism spectrum disorders, and improve a body function. Covered Medical Services do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.

39. **Organ transplant.** Medically Necessary charges Incurred for the care and treatment due to an organ or tissue transplant that is not considered Experimental or Investigational, subject to the following criteria:

- The transplant must be performed to replace an organ or tissue.

- Organ transplant benefit period. A period of 365 continuous days beginning five days immediately prior to an approved organ transplant procedure. In the case of a bone marrow transplant, the date the transplant begins will be defined as either the earlier of the date of the beginning of the preparatory regimen (marrow ablation therapy) or the date the marrow/stem cells are infused.

- Organ procurement limits. Charges for obtaining Donor organs or tissues are Covered Medical Services under the Plan only when the recipient is a Plan Participant. When the Donor has medical coverage, his or her plan will pay first. The Donor benefits under this Plan will be reduced by those payable under the Donor's plan. Donor charges include those for:

    i. Evaluating the organ or tissue;
    ii. Removing the organ or tissue from the Donor; and
    iii. Transportation of the organ or tissue from within the United States or Canada to the Facility where the transplant is to be performed.

Note: Expenses related to the purchase of any organ will not be covered.

Covered Medical Services must be provided by a "Transplant Facility Partner". Transplant Facility Partners are Facilities (i) that have entered into a contract with a national transplant network being utilized by the Plan and (ii) are designated by that transplant network as one of their highest tiered Facilities for the specific transplant based on performance guidelines and cost criteria. Highest tiered Facilities are sometimes referred to as Centers of Excellence or Designated Facilities by the national transplant network.

Coverage for the following procedures *(sometimes referred to as a transplant procedure)*, when Medically Necessary, may be provided under the regular medical benefits under this Plan, subject to all Plan provisions and applicable benefit limitations as stated under this Plan:

- Cornea transplant
- Skin grafts
- Artery
- Vein
- Valve
- Transplantation of blood or blood derivatives (except for bone marrow or stem cells)

<u>Transportation and Lodging</u>

Transportation
When the Plan Participant resides 50 miles or more from the covered transplant Facility, the Plan will reimburse the following reasonable transportation expenses Incurred during the transplant benefit period subject to the maximum benefit as specified in the Medical Benefits Schedule.

Transportation expenses to and from the covered transplant Facility for the following individuals:

- The Plan Participant; and
    - One or both parents of the Plan Participant (only if the Plan Participant is a Dependent minor

child); or
    - One adult to accompany the Plan Participant; and
- The living Donor (if applicable under the Plan).

Transportation expenses include commercial transportation (coach class only).

Lodging
When the Plan Participant resides 50 miles or more from the covered transplant Facility, the Plan will reimburse the following reasonable lodging expenses Incurred during the transplant benefit period subject to the maximum benefit as specified in the Medical Benefits Schedule:

- The Plan Participant (if applicable, i.e. if not inpatient); and
    - One or both parents of the Plan Participant (only if the Plan Participant is a Dependent minor child), or
    - One adult companion who is accompanying the Plan Participant; and
- The living Donor (if applicable under the Plan).

Lodging, for purposes of this Plan, will not include private residences.

40. **Orthotic Appliances.** The initial purchase, fitting, and repair of orthotic appliances such as braces (except dental braces), splints, casts, or other appliances which are required for support of an injured or deformed part of the body as a result of a disabling congenital condition, Injury, or Illness.

41. **Orthotic Insoles.** The charges for orthotic insoles for the feet when prescribed by a Physician for diabetic foot care or patients with peripheral vascular disease only, medically designed for the Plan Participant.

42. **Physical Therapy.** The charges for physical therapy must be in accordance with a Physician's exact orders as to type, frequency, and duration for conditions which are subject to significant improvement through short-term therapy. Covered Medical Services include treatment of autism spectrum disorders.

43. **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for multiple surgical procedures are subject to the following provisions in the absence of a negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement:

a. If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Allowable Charge for the primary procedure; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision or during the same operative session. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
b. If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Allowable Charge percentage allowed for that procedure; and
c. If an assistant surgeon is required, the assistant surgeon's Covered Medical Service will not exceed 20% of the surgeon's Allowable Charge.

44. **Pregnancy.** The charges for the care and treatment of Pregnancy are covered the same as any other Illness.

Note: Routine prenatal office visits will be payable as shown under the Pregnancy benefit in the Medical Benefits Schedule. The following services will continue to be payable per normal Plan provisions:

Pregnancy-related ultrasounds, lab screenings (not otherwise specified), Complications of

Pregnancy (as defined under this Plan), delivery, and post-partum care .

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

45. Preventive Care/Routine Well Care.

Preventive Care/Routine Well Care is care by a Physician that is not for an Injury or Illness and will only apply in the absence of a diagnosis for a medical condition, including a recurring condition or for medication.

The Plan Participant should consult with his/her Physician at the time services are rendered as to whether or not the services provided will be considered Preventive Care/Routine Well Care as mandated under the Affordable Care Act (ACA), U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations or the Women's Preventive Services as required by the Health Resources, Services Administration (HRSA) and Healthcare.gov.

Otherwise, services rendered which are not considered or billed by the Physician as Preventive Care/Routine Well Care (as stated above) will be subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided.

46. Prosthetic Devices. The initial purchase, fitting, repair and Medically Necessary replacement of fitted prosthetic devices which replace body parts.

47. Reconstructive Surgery. Covered Medical Services include reconstructive surgery performed to correct significant deformities caused by congenital or developmental abnormalities, Illness, Injury, and reconstructive mammoplasties.

Mammoplasty coverage will include reimbursement for:

a. reconstruction of the breast on which a mastectomy has been performed,
b. surgery and reconstruction of the other breast to produce a symmetrical appearance, and
c. coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas
d. custom bras for prostheses following a mastectomy.

48. Retail Health Clinic. The charges for limited basic health care services to Plan Participants on a "walk-in" basis at a Retail Health Clinic, payable as shown in the Medical Benefits Schedule. Retail Health Clinics are normally found in major Pharmacies or retail stores. Health care services are typically used for the treatment of common Illnesses for adults and children.

49. Skilled Nursing Facility Care. The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

a. the Plan Participant is confined as a bed patient in the Facility; and
b. the attending Physician certifies that the confinement is deemed Medically Necessary; and
c. the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

50. Speech Therapy. The charges for speech therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy); (ii) an Injury; (iii) an Illness; or (iv) in treatment of autism spectrum disorders.

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

52. **Sterilization Procedures.** The charges for sterilization procedures for female Plan Participants consistent with the Affordable Care Act Preventive Services requirement. Sterilization for male Plan Participants will be payable per normal Plan provisions.

53. **Telehealth**. Telehealth services will be a Covered Medical Service subject to the same deductible, copayment, or coinsurance requirements that apply to comparable health services provided in person. *Telehealth services may be available outside the medical benefits of this Plan at minimal or no cost to the Plan Participant. Employees should contact their Human Resources Department for more information.*

54. **Tobacco/Nicotine Cessation Counseling.** The charges for Tobacco/Nicotine Cessation Counseling consistent with the Affordable Care Act Preventive Services requirement.

55. **Urgent Care Services.** The charges for care and treatment for an Illness, Injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

56. **Vision Exam.** The charges for a vision examination including eye refractions.

57. **Well Newborn Nursery/Physician Care.**

Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board, and other normal well-baby care, including circumcision, for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible and enrolled Dependent and a parent (1) is a Plan Participant who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

Covered Medical Services for routine nursery care will be applied toward the Plan of the covered newborn child, provided the newborn child is enrolled on a timely basis.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Routine Physician Care. This benefit is for routine well-baby care made by a Physician for pediatric visits to the newborn child, including circumcision, while Hospital confined as a result of the child's birth.

Covered Medical Services for routine Physician care will be applied toward the Plan of the covered newborn child, provided the newborn child is enrolled on a timely basis.

PLAN EXCLUSIONS

The following exclusions and limitations apply to expenses Incurred by all Plan Participants:

Abortion. The charges related to an elective abortion, unless the life of the covered mother is endangered or the Pregnancy is the result of rape or incest.

Adoption Fees. Charges for adoption fees.

Alternative Medicine. The charges for care, treatment, services or supplies related to alternative medicine that is not an accepted medical practice as determined by the Plan, except as specifically shown as a Covered Medical Service under this Plan.

Biofeedback. Charges for biofeedback.

Coding guidelines. Charges for inappropriate coding in accordance with the industry standard guidelines in effect at the time services were received.

Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment not covered under the Plan. Complications from a non-covered abortion are covered.

Cosmetic Procedures. Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, cosmetic surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by Injury, disease, trauma, congenital/developmental anomalies, or previously covered therapeutic processes or as specifically shown as a Covered Medical Service under this Plan.

Counseling. Care and treatment for marital or pre-marital, relationship, or financial counseling.

Custodial Care. Services or supplies provided mainly as a rest cure, maintenance, Custodial Care or domiciliary care consisting chiefly of room and board, except as specifically shown as a Covered Medical Service under this Plan.

Dental services. Care, treatment, services and supplies including appliances in connection with dental services and oral surgery, except as specifically shown as a Covered Medical Service under this Plan.

Durable Medical Equipment Repair. Charges for repair, adjustment or replacement of rented Durable Medical Equipment or components.

Educational or vocational testing. Services for educational or vocational testing or training, except as specifically stated as a Covered Medical Service under this Plan.

Excess charges. The part of an expense for care and treatment of an Injury or Illness that is in excess of the Allowable Charge.

Exercise programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

Experimental or not Medically Necessary. Care and treatment that is either Experimental/ Investigational or not Medically Necessary except as provided consistent with the Affordable Care Act preventive services requirements.

Fees. Charges for completion of form fees, missed appointment fees or late fees.

Foot care (routine). Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except

open cutting operations), and treatment of corns, calluses or toenails (unless deemed Medically Necessary).

Foot orthotics (other than Medically Necessary foot orthotics immediately following foot surgery), corrective shoes, unless they are an integral part of a lower body brace; arch supports; and special shoe accessories.

Foreign travel. Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

Government coverage. Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

Hair loss/Wigs. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

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

Illegal Acts. Charges for services received as a result of an Illness or Injury occurring directly, or indirectly as a result of a serious criminal act, or a riot or public disturbance, regardless of causation. For this exclusion to apply, it is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment for a term be imposed.

Charges for services, supplies, care or treatment to a Plan Participant for an Injury or Illness which occurred as a result of that Plan Participant while under the influence of alcohol or drugs, or a combination thereof. It is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment for a term be imposed

This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Impotence. Care, treatment, services, supplies or medication in connection with treatment for impotence or sexual dysfunction.

Incarcerated. Care, treatment, services, and supplies Incurred and/or provided to a Plan Participant by a government entity while housed in a governmental institution.

Infertility. The charges for the services to restore or enhance fertility, including, but not limited to, artificial insemination, in vitro fertilization, embryo transfer procedures.

Mailing or Sales Tax. Charges for mailing, shipping, handling, postage, conveyance, and sales tax.

Massage Therapy. Charges for massage therapy.

No charge. Care and treatment for which there would not have been a charge if no coverage had been in force.

No obligation to pay. Charges Incurred for which the Plan has no legal obligation to pay.

No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.

Non-emergency Hospital admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

Occupational Injury. Care and treatment of an Injury or Illness that is occupational – that is, arises from work for wage or profit including self-employment. This exclusion applies even though the Plan Participant:

a. Has waived his/her rights to Workers' Compensation benefits;
b. Was eligible for Workers' Compensation benefits and failed to properly file a claim for such benefits; or
c. Is permitted to elect not to be covered under Workers' Compensation and has affirmatively made that election.

Orthognathic Surgery. Charges for orthognathic surgery.

Personal comfort items. Personal comfort items, patient convenience items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, non-Prescription Drugs and medicines, first-aid supplies, and non-Hospital adjustable beds.

Plan design excludes. Charges excluded by the Plan design as mentioned in this document or that exceed a listed limit under this Plan.

Private duty nursing. Charges in connection with care, treatment or services by a private duty nurse.

Relative giving services. Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Replacement braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Plan Participant's physical condition to make the original device no longer functional.

Routine care. Charges for routine or periodic examinations and evaluation procedures, physical exams and immunizations related to travel, employment, insurance, sports, licensing, etc., or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Illness, or Pregnancy-related condition, which is known or reasonably suspected, except as specifically stated as a benefit under this Plan or required by applicable law.

Services before or after coverage. Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan.

Surgical sterilization reversal. Care and treatment for reversal of surgical sterilization for men or women.

Surrogate Fees. Charges for surrogate fees.

Temporomandibular Joint (TMJ) Disorders. The charges for medical treatment of Temporomandibular Joint (TMJ) Syndrome and related services.

Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically stated as a benefit under this Plan.

Vision Eyewear. Charges Incurred in connection with the purchase or fitting of eyeglasses and contact lenses, and charges for any procedure for the correction of a visual refractive problem including radial keratotomy, LASIK or similar surgical procedures. This exclusion/limitation shall not apply to routine vision screenings as provided by the Affordable Care Act Preventive Services requirements, or the initial purchase of required eyeglasses or contact lenses following a covered eye surgery.

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

PRESCRIPTION DRUG BENEFITS

Participating Pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. **EmpiRX** is the administrator of the Pharmacy drug plan.

Eligible expenses Incurred through the Prescription Drug benefits of this Plan apply to the maximum out-of-pocket amount as shown in the Medical Benefits Schedule.

PARTICIPATING RETAIL PHARMACY

Any one retail participating Pharmacy prescription is available up to a 30-day supply per prescription.

If a drug is purchased when the Plan Participant's ID card is not used, the Plan Participant will be required to pay 100% of the total cost at the point of sale, no discount will be given, and the Plan Participant will be required to submit the prescription receipt to **EmpiRX** for reimbursement (less applicable copayments as shown in the Prescription Drug Benefits Schedule).

MAIL ORDER PHARMACY

Any one mail order Pharmacy prescription is available up to a 90-day supply per prescription.

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Plan Participants significant savings on their prescriptions.

SPECIALTY PHARMACY

Specialty medications are limited to a 30-day supply per prescription.

Specialty medications are high-cost injectables, infused, oral, or inhaled medications prescribed in the treatment of chronic and life-threatening diseases including but not limited to: multiple sclerosis, rheumatoid arthritis, Hep C, hemophilia, chronic kidney disease, Crohn’s disease, or osteoarthritis.

PREVENTIVE CARE COVERAGE

The following will be covered at 100%, no copayment required for formulary drugs:

1. Physician-prescribed contraceptive methods (Food and Drug Administration (FDA) approved) including but not limited to oral contraceptive medications, transdermals, devices (diaphragms, cervical caps, and intra-uterine devices (IUDs)), vaginal contraceptives, implantables, injectables, female condoms, spermicides, and sponges for all female Plan Participants with reproductive capacity.

   Refer to the Covered Medical Services of this Plan regarding additional coverage for intrauterine devices (IUDs), implantables, and injectables.

2. Physician-prescribed tobacco/nicotine cessation medications or products. Physician-prescribed tobacco/nicotine replacement products (such as nicotine patch, gum, lozenges) and Physician-prescribed medications.

3. Certain vaccinations/immunizations as recommended by applicable federal law.

4. Additional Physician-prescribed medications as recommended by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations will be covered at 100%, no prescription copayment, coinsurance or deductible will be required.

   Please note, the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations may change. Coverage of new recommended medications will be available

following the one-year anniversary date of the adoption of the USPSTF grade A and B recommendation.

Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact EmpiRX for more information regarding which medications are available. Note: Age and/or quantity limitations may apply:

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

Limits To This Benefit

The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a Physician.
2. Refills up to one year from the date of order by a Physician.

HOW TO SUBMIT PHARMACY CLAIMS

EmpiRX
5950 Hazeltine National Dr. Suite 300
Orlando, FL 32822
Empirxhealth.com

HOW TO SUBMIT A CLAIM

A “Claim” means a request for a Plan benefit made by a Claimant (the Plan Participant or an authorized representative) after medical treatment has occurred. When services are received from a health care provider, a Plan Participant should show their Group Health identification card to the provider. Providers may submit Claims on a Plan Participant’s behalf.

If it is necessary for a Plan Participant to submit a Claim, they should request an itemized bill from their health care provider which will include procedure (CPT) and diagnostic (ICD) codes.

The following information must be provided when submitting a Claim for processing:

- A copy of the itemized bill
- Group name and number (ARDENT HEALTH SERVICES GROUP HEALTH PLAN, Group 0070900)
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

WHEN CLAIMS SHOULD BE FILED

Claims should be received by the Claims Administrator within 365 days from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

WHERE TO SUBMIT CLAIMS

Claims for expenses should be submitted to the applicable address below:

Imagine360 Administrators, LLC
6101 South Broadway Suite 300
Tyler, TX 75703
(844) 573-1905

INTERNAL AND EXTERNAL REVIEW PROCEDURES

A "Claim" means a request for a Plan benefit made by a Claimant (the Plan Participant or an authorized representative) after medical treatment has occurred. A Claim is not a request to determine a Claimant's eligibility for benefits, nor is it a request for a Pre-Service Review prior to receiving medical treatment to determine Medical Necessity.

A Claimant may appoint an authorized representative to act upon his or her behalf with respect to a Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is not an authorized representative simply by virtue of an assignment of benefits. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives.

PRE-SERVICE REVIEW

A Pre-Service Review may be requested as explained in the Utilization Management section of this Plan. A Pre-Service Review may be recommended by the Plan, or it may be required by the Plan as a condition precedent to paying benefits. A Pre-Service Review resulting in an adverse determination cannot be appealed under the Plan's Internal and External Review Procedures. See the Utilization Management section to request an initial Pre-Service Review or to request a reconsideration of an adverse Pre-Service Review determination.

A Pre-Service Review may also include a reconsideration of an adverse determination for Concurrent Care if the service has not been Incurred and the Plan Participant has been given ample time in which to request a reconsideration prior to the reduction or termination of the Concurrent Care.

Adverse determinations related to "Concurrent Care" may arise when the Plan has approved an on-going course of treatment to be provided over a period of time or for a specific number of treatments. If the Plan determines that the previously approved course of treatment should be reduced or terminated, the Plan must allow the Claimant sufficient notice in advance of further treatment to allow the Claimant to request reconsideration of the adverse determination prior to the reduction or termination of the Concurrent Care. To request a reconsideration, the Claimant must follow the instructions for submitting an adverse Pre-Service Review as explained in the Utilization Management section.

Adverse determinations related to "Concurrent Care" may also occur during a Plan Participant's inpatient Facility stay. If the inpatient Facility stay continues beyond the number of days approved as part of the Concurrent Care review, the Plan must allow the Claimant sufficient notice in advance of further treatment to allow the Claimant to request reconsideration of the adverse determination prior to the reduction or termination of the Concurrent Care. To request a reconsideration, the Claimant must follow the instructions for submitting an adverse Pre-Service Review as explained in the Utilization Management section.

The Claimant must indicate when requesting a reconsideration of the adverse determination for Concurrent Care if the request is of an urgent nature. When an urgent care request exists, the Plan is required to respond in an expedited manner, but the request must be received at least 24 hours prior to the expiration or reduction of the existing Concurrent Care approval.

POST- SERVICE CLAIM

A Post-Service Claim is a Claim for medical care, treatment, or services that a Claimant has already received.

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were Incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about Claims involving specialized medical knowledge or judgment.

Initial Benefit Determination

A Claim will not be deemed submitted until it is received by the Claims Administrator. The initial benefit determination

on a Claim will be made within 30 days of the Claim Administrator's receipt of the Claim (or 15 days if the Claim is a Concurrent Care Determination). If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits. If additional information is requested, the Plan's time period for making a determination is suspended until such time as the Claimant provides the information, or the end of the 45-day period, whichever occurs earlier. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information. Under the No Surprises Act, the Plan will have up to 30 calendar days to send a notice of denial of payment or an initial payment to the Provider from the time the Claim is resubmitted with additional information.

Notice of Adverse Benefit Determination

If a Claim is denied in whole or in part, the Plan shall provide the Claimant with an Explanation of Benefits (EOB), and/or provide written or electronic notice of the determination to providers, that will include the following:

1. Information to identify the Claim involved.

2. Specific reason(s) for the denial, including the denial code and its meaning.

3. Reference to the specific Plan provisions on which the denial was based.

4. Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

5. Description of the Plan's Internal and External Review Procedure and the applicable time limits. This will include a statement of the Claimant's right to bring a civil action once the Claimant has exhausted all available internal and external review procedures.

6. Statement that the Claimant 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 Claim.

If applicable:

1. Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim.

2. If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim.

3. Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the Explanation of Benefits/Explanation of Payment.

An Adverse Benefit Determination also includes a rescission of coverage when applied as a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, nor is it a retroactive cancellation or discontinuance due to the Plan Participant's failure to pay the required premium in a timely manner.

How to Appeal an Adverse Benefit Determination

A Claimant may appeal an Adverse Benefit Determination. The Plan offers two-levels of review; an Internal Review procedure and an External Review procedure that will allow the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by an individual who is neither the person who made the determination on a prior level of review, nor a subordinate of that person. Additionally, if an External Review is requested, that review will be conducted by an Independent Review Organization that was not involved in any of the prior determinations.

In addition, the Plan Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the Claim, without regard as to whether this information was submitted or considered in a prior level of review.

- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final Adverse Benefit Determination so that the Claimant has a reasonable amount of time to respond.

- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's Adverse Benefit Determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

Note: When the dispute of a Claim payment or denial only involves payment amounts due from the Plan to the Non-Network Provider, and the provider has no recourse against the Plan Participant under the No Surprises Act, the payment dispute may only be resolved through open negotiation, or the Independent Dispute Resolution (IDR) process as outlined in the NSA. There may be instances when a Plan Participant may appeal a Claim through this section concurrently with a Non-Network Provider's payment dispute through the IDR process.

INTERNAL REVIEW PROCEDURE

First Level of Internal Review

The written request for a First Level Internal Review must be submitted within 180 days of the Claimant's receipt of an Explanation of Benefits/Explanation of Payment that includes the adverse benefit determination.

The Claimant should include the following information in their request for review:

- Name of the covered Employee

- Name and date of birth of the Plan Participant who Incurred the charges

- Name of the Group Health plan and the identification number (as shown on the Group Health coverage ID card)

- A statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim.

- All facts and theories supporting the Claim for benefits. Failure to include any theories or facts in the appeal will result in such facts being inadmissible. In other words, the Claimant will lose the right to raise such factual arguments and theories which support this Claim if the Claimant fails to include them in the appeal;

- A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the Claim; and

- Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

The First Level of Internal Review request should be addressed to:

Plan Administrator
c/o Imagine360 Administrators, LLC
6101 South Broadway Suite 300
Tyler, TX 75703
(844) 573-1905

An appeal will not be deemed submitted until it is received by the Claims Administrator. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely request for a First Level Internal Review.

The First Level of Internal Review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal. The Notice of Determination resulting from a First Level Internal Review shall meet the requirements as stated above.

Second Level of Internal Review

If the Claimant does not agree with the determination from the First Level of Internal Review, the Claimant may submit a Second Level Internal Review request in writing within 60 days of the Claimant's receipt of the Notice of Determination from the First Level of Internal Review, along with any additional supporting information.

The Second Level of Internal Review request should be addressed to:

Plan Administrator
c/o Imagine360 Administrators, LLC
6101 South Broadway Suite 300
Tyler, TX 75703
(844) 573-1905

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. The Claimant cannot proceed with an External Review or file suit if the Claimant fails to submit a timely appeal.

The Second Level of Internal Review will be completed by the Plan Administrator and/or its designee. The Plan Administrator/designee will review the information initially received and any additional information provided by the Claimant and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator/designee will send a written or electronic Notice of Determination for the Second Level of Internal Review to the Claimant within 30 days of receipt of the appeal (or 15 days for an appeal of a Concurrent Care Claim Determination). The Second Level of Internal Review Notice of Determination shall meet the requirements as stated above.

If the Claimant is not satisfied with the outcome of the final determination on the Second Level of Internal Review, the Claimant may request an External Review. The Claimant must exhaust the First and Second Levels of Internal Review before requesting an External Review unless the Plan Administrator did not comply fully with the Plan's Internal Review Procedure for the First Level of Internal Review.

EXTERNAL REVIEW PROCEDURE

This Plan has an External Review Procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within four months from the date of receipt of the notice of the Final Internal Review Adverse Benefit Determination or the first day of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a Claim, except where such request is limited by applicable law.

A request for External Review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or service is not Medically Necessary.
- Determination that a treatment is Experimental or Investigational.
- Rescission of coverage, whether or not the rescission involved a Claim.
- Violation of cost-sharing and surprise billing protections as identified within the No Surprises Act (NSA).
- Application of treatment limits to a Claim for a Mental Disorder.

For an Adverse Benefit Determination to be eligible for External Review, the Claimant must complete the required forms to process an External Review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within six business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for External Review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four-month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for External Review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law. Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the Final Level of Internal or External Review, whichever is applicable.

PROVIDER OF SERVICE APPEAL RIGHTS – CLAIM REVIEW AND AUDIT PROGRAM

A Claimant may appoint the provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied Claim. An assignment of benefits by a Claimant to a provider of service will not constitute appointment of that provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied Claim, and as a courtesy to a provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the provider in the same manner as a Claimant's appeal and will respond to the provider and the Claimant with the results of the review accordingly. Any such appeal from a provider of service must be made within the time limits and under the conditions for filing an appeal specified under the section, "Internal and External Review Procedures" above. Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Medical Services directly from the Plan, waiving any right to recover such expenses from the Claimant, and comply with the conditions of the section, "Internal and External Review Procedures", above.

For purposes of this section, the provider's waiver to pursue Covered Medical Services does not include the following amounts, which will remain the responsibility of the Claimant:

- Deductibles;
- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the Plan;
- Charges for services and supplies which are not included for coverage under the Plan; and
- Amounts which are in excess of any stated Plan maximums or limits. Note: This does not apply to amounts found to be in excess of Allowable Claim Limits, as defined in the section, "Claim Review and Audit Program." The provider must agree to waive the right to balance bill for these amounts.

Also, for purposes of this section, if a provider indicates on a Form UB04 or on a CMS – 1500 Form (or similar claim form) that the provider has an assignment of benefits, then the Plan will require no further evidence that benefits are legally assigned to that provider.

Contact the Claims Administrator or the Plan Administrator for additional information regarding provider of service appeal rights.

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 Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant on whose behalf such payment was made, using any recovery method permitted by law.

A Plan Participant, 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 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any Claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor, to the extent allowed by law. 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, agree to be bound by the terms of this Plan and agree to submit Claims for reimbursement in strict accordance with their State's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator. Any payments made on Claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants, beneficiaries, estate, heirs, guardian, personal representative, or assignees (Plan 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 Plan Participant(s) are entitled, for or in relation to Facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

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

1. In error;

2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;

3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;

4. With respect to an ineligible person;

5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's 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 an Employee or by any of his covered Dependents if such payment is made with respect to the Employee or any person covered or asserting coverage as a Dependent of the Plan Participant.

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

COORDINATION OF BENEFITS

Coordination of the benefit plans. The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Medical Services when two or more plans – including Medicare – are paying. The Plan has adopted the order of benefits as set forth in the National Association of Insurance Commissioners (NAIC) Model COB Regulations, as amended. When a Plan Participant is covered by this Plan and another plan, or the Plan Participant's Spouse (which is defined to include Domestic Partner, if applicable, in this section) is covered by this Plan and by another plan, or the couple's covered children are covered under two or more plans the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plans involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical and prescription drug and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

1. Group or nongroup insurance contracts and subscriber contracts;

2. Uninsured arrangements of group or group-type coverage;

3. Group and nongroup coverage through closed panel plans;

4. Group-type contracts;

5. The medical components of long-term care contracts, such as skilled nursing care;

6. Medicare or other government benefits, as permitted by law. This does not include Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan;

7. The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts;

8. Any third-party source, including but not limited to, automobile or homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident or non-medical long-term care coverage.

Allowable Charge(s). For a charge to be allowable, it must be a usual, customary, and reasonable charge and at least part of it must be covered under this Plan. (See "Allowable Charge" in the Definitions section.)

In the case of Health Maintenance Organization (HMO) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Plan Participant does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Plan Participant used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

2. Plans with a coordination provision will pay their benefits up to the Allowable Charge.

The first rule that describes which plan is primary is the rule that applies:

a. The benefits of the plan which covers the person directly (that is, as an Employee, Retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B"). For COBRA Qualified Beneficiaries, coordination is determined based on the person's status prior to the COBRA Qualifying Event.

Special rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is Retired), THEN Plan B will pay first.

b. Unless there is a Medical Child Support Order stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan, the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

- The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

- If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

When a child's parents are divorced, legally separated or not living together, whether or not they have ever been married, these rules will apply:

- A Medical Child Support Order may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the financially responsible parent has no health care coverage for the Dependent child, but that parent's spouse does, the plan of that parent's spouse is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree;

- A Medical Child Support Order may state both parents will be responsible for the Dependent child's health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);

- If the specific terms of the Medical Child Support Order state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

If there is no Medical Child Support Order allocating responsibility for the Dependent child's health care expenses, the order of benefits are as follows:

1st The plan covering the custodial parent,
2nd The plan covering the spouse of the custodial parent,
3rd The plan covering the non-custodial parent, and
4th The plan covering the spouse of the non-custodial parent.

When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

Unless specifically stated otherwise, Medical Child Support Order and custody provisions apply up to age 19 for any Dependent child.

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, Rule (e) applies. If the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's spouse.

c. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor Retired or as a Dependent of an Employee who is neither laid off nor Retired are determined before those of a plan which covers that person as a laid-off or Retired Employee. This rule does not apply if Rule (a) can be used to determine the order of benefits. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

d. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor Retired or a Dependent of an Employee who is neither laid off nor Retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (a) can be used to determine the order of benefits.

e. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

3. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

4. The Plan will pay primary to Tricare to the extent required by federal law.

COORDINATION WITH MEDICARE

Notwithstanding all other provisions of this Plan, Plan Participants who are eligible for Medicare benefits may be entitled to benefits under this Plan which will be coordinated with Medicare in accordance with the Coordination of Benefits provision of this Plan and subject to the rules and regulations as specified by the Tax Equity and Fiscal Responsibility Act of 1982 as may be amended from time to time. This Plan is primary to Medicare coverage for all Active Employees and Dependents (regardless of age) unless Medicare states otherwise or for certain medical conditions. In the event that this Plan is secondary to Medicare and the Plan Participant is enrolled under Part A, Part B, or both, benefits payable under this Plan will be reduced by benefits that would be payable for the same services under Medicare Parts A and B.

Medicare Secondary Payer Rules

Medicare is the primary payor (and the Plan is the secondary payor) for:

- Plan Participants with end stage renal disease (ESRD) beginning 30 months after the ESRD-based Medicare entitlement.

- Plan Participants 65 or older, who are covered under Medicare as the result of age, when the employer has less than 20 employees.

- Plan Participants under age 65, who are covered by Medicare because of disability (other than ESRD), when the Plan Participant has coverage due to current employment status and the employer employs less than 100 employees.

- Plan Participants under age 65, who are covered by Medicare because of disability (other than ESRD), when the Plan Participant has coverage not due to current employment status (e.g., COBRA or retiree coverage).

If Medicare is the primary payor (and the Plan is the secondary payor), the benefits under the Plan are not intended to duplicate any benefits to which Plan Participants are, or would be, entitled under Medicare. Plan Participants must complete any documents or authorizations as may be requested by the Plan in order to obtain reimbursement by Medicare. The Plan will not reduce the benefits due to that Plan Participant's eligibility for Medicare where federal law requires that the Plan determine the benefits for that Plan Participant without regard to the benefits available under Medicare. This section will apply to the maximum extent permitted by federal or state law.

COORDINATION WITH AUTOMOBILE INSURANCE COVERAGE

The Plan's liability for expenses arising out of an automobile Accident is based on the type of automobile insurance law enacted by the Plan Participant's State. Nationally, there are three types of State automobile insurance laws:

1. No-Fault Automobile Insurance laws;
2. Financial responsibility laws; or
3. Other automobile liability insurance laws.

Coordination With Automobile No-fault Coverage. Except as required by law, the Plan is secondary to any No-Fault Automobile coverage. It is not intended to reduce the level of coverage that would otherwise be available through a No-Fault Automobile Insurance policy nor does it intend to be primary in order to reduce the premiums or cost of No-Fault Automobile coverage.

If the Plan Participant incurs Covered Medical Services as a result of an automobile Accident (either as driver, passenger or pedestrian), the amount of Covered Medical Services that the Plan will pay is limited to:

1. Any Deductible under the automobile coverage;
2. Any Copayment under the automobile coverage;
3. Any expense properly excluded by the automobile coverage that is a Covered Medical Service; and
4. Any expense that the Plan is required to pay by law.

An individual is considered to be covered under an automobile insurance policy if he/she is either:

1. An owner or principal named insured of the policy;
2. A Family member of a person insured under the policy; or
3. A person who would be eligible for medical expense benefits under an automobile insurance policy if this Plan did not exist.

Coordination With Financial Responsibility Law. The Plan is secondary to automobile coverage or to any other party who may be liable for the Plan Participant's medical expenses resulting from the automobile Accident. If the Plan Participant's State has a "financial responsibility" law which does not allow the Plan to pay benefits as secondary or which does not allow the Plan to advance payments with the intent of subrogating or recovering the payment, the Plan will not pay any benefits related to an automobile Accident for the Plan Participant.

Coordination With Other Automobile Liability Insurance. If the Plan Participant's State does not have a No-Fault Automobile Insurance law or a "financial responsibility" law, this Plan is secondary to their automobile insurance coverage or to any other party who may be liable for the Plan Participant's medical expenses resulting from the automobile Accident.

Coordination With Underinsured/Uninsured Motorist Coverage. If the Plan Participant is involved in an automobile Accident and, as a result of the Accident, the Plan pays benefits, and if the Plan Participant receives a settlement from their underinsured or uninsured motorist policy, the Plan is entitled to receive from the proceeds of the settlement with the underinsured or uninsured motorist coverage, the expenses of the Plan. The Plan is not entitled to receive any recovery that is in excess of its expenses. The Plan agrees to payment of benefits prior to the receipt by the Plan Participant of any recovery from their underinsured or uninsured motorist policy. The Plan Participant agrees to notify the Plan of the existence of a recovery from an underinsured or uninsured motorist policy

and further agrees to remit to the Plan the proceeds of any recovery received from an underinsured or uninsured motorist policy up to the expenditures made by the Plan. Any expenses by the Plan which are in excess of the proceeds received by the underinsured/uninsured motorist policy will be the responsibility of the Plan pursuant to the terms and conditions of the Plan.

Claims determination period. Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Medical Benefits Schedule. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Plan Participant will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Claims Administrator determines the Plan should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Plan Participant. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA (if applicable), the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Plan Participant under the Plan.

SUBROGATION AND REIMBURSEMENT PROVISIONS

PAYMENT CONDITION

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, beneficiaries, estate, heirs, guardian, personal representative, or assignees (collectively referred to hereafter in this section as "Plan Participant(s)") or a third party, where another party 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. A Plan Participant(s), his/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 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or his/her 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 Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits, the Plan Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Plan Participant shall be a trustee over those Plan assets.

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

4. If there is more than one party responsible for charges paid by the Plan, or that 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, in regard to an unallocated settlement fund meant to compensate multiple injured parties of which the Plan 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.

SUBROGATION

1. As a condition to participating in and receiving benefits under this Plan, the Plan 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 Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Plan Participant(s) fails to so pursue said rights and/or action.

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

3. The Plan may, at its discretion, in its own name or in the name of the Plan 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 Plan 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 coverages;

    then the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such Claims in the Plan Participant(s) and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such Claims. The Plan 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.

RIGHT OF REIMBURSEMENT

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

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express 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 Plan 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 Plan 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 Illness, Injury, or disability.

PARTICIPANT IS A TRUSTEE OVER PLAN ASSETS

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

    a. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
    b. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
    c. In circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement, judgment, or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and
    d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

RELEASE OF LIABILITY

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

EXCESS INSURANCE

If at the time of Injury, Illness, 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.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan 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.

WRONGFUL DEATH CLAIMS

In the event that the Plan Participant(s) dies as a result of his/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.

OBLIGATIONS

1. It is the Plan Participant(s) obligation at all times, both prior to and after payment of benefits by the Plan to:

    a. 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. Provide the Plan with pertinent information regarding the Illness, disability, or Injury, including Accident reports, settlement information and any other requested additional information;
    c. Take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    d. Do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    e. Promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received;
    f. Notify the Plan or its authorized representative of any incident related claims or care which may not be identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan;
    g. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
    h. Not settle or release, without the prior consent of the Plan, any Claim to the extent that the Plan Participant's Beneficiary may have against any responsible party or Coverage;
    i. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;
    j. In circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
    k. Make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Participant over settlement funds is resolved.

2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Plan 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 Plan Participant(s).

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

OFFSET

If timely repayment is not made, or the Plan Participant(s) and/or his or 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 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. This provision applies even if the Plan Participant has disbursed settlement funds.

MINOR STATUS

1. In the event the Plan 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/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 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.

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 Sponsor may amend the Plan at any time without notice.

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.

RIGHT TO RECOVER BENEFITS PAID IN ERROR

The Plan has the right to recover any benefits the Plan paid in error to the Plan Participant or on behalf of a Plan Participant to which the Plan Participant is not entitled, for services which were not covered under the Plan, or for benefits paid in excess of the Plan's Allowable Charges. The Plan may recover benefits paid in error from the Plan Participant, the provider who received a payment from the Plan on the Plan Participant's behalf, or from any person who may have benefited. The Plan may also offset any future benefits otherwise payable to or on the Plan Participant's behalf, or from any other Plan Participant enrolled through the same covered Employee (or Retiree, if applicable).

COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to You and other members of Your family when group health coverage would otherwise end. You should check with Your Employer to see if COBRA applies to You and Your Dependents.

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 otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, Your Spouse, and Your Dependent children 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.

Note: "Qualified Beneficiary" is a term defined under IRS COBRA regulations to mean a covered Employee, the spouse of a covered Employee, or the Dependent Child of a covered Employee. Continuation coverage for Domestic Partners and their Dependents is offered voluntarily by the Employer and is not required by or subject to COBRA. As this is COBRA-equivalent coverage, a Domestic Partner will be treated as a Qualified Beneficiary to the same extent as if the Domestic Partner were the Employee's spouse and will have independent election rights, including in the event of the covered Employee's death. In addition, the Dependent Children of a covered Domestic Partner will be treated as "Qualified Beneficiaries" for these purposes to the same extent that Dependents of a spouse would be so treated and will have independent election rights, including in the event of the covered Employee's death. Although the Plan will treat a Domestic Partner as a "Qualified Beneficiary," this treatment does not qualify a Domestic Partner as a "Qualified Beneficiary" under IRS COBRA final regulations.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred.

If You are a covered Employee, You will become a Qualified Beneficiary if You lose Your coverage under the Plan due to one 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 are the Spouse of a covered Employee, You will become a Qualified Beneficiary if You lose Your coverage under the Plan due to one 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; or
- You become divorced or legally separated from Your Spouse.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee's hours of employment are reduced;

- The parent – covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the Plan as a "Dependent child."

If this Plan provides Retiree health coverage, 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 the 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 children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan Administrator must be notified within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

Plan Administrator
AHS MANAGEMENT COMPANY, INC.
340 Seven Springs Way Ste 100
Brentwood, TN 37027
(615) 296-3000

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered, on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?
Once the Plan Administrator 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 Dependent children.

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

How long does COBRA Continuation Coverage last?
COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the 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 Qualified 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, discussed below.

If 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), Your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

Medicare extension of COBRA Continuation Coverage

Entitlement to Medicare is not considered a traditional secondary Qualifying Event for a covered Dependent; however, Medicare entitlement does provide potentially longer periods of continuation coverage to certain Qualified Beneficiaries based on the sequence of events. If a covered Employee becomes entitled to Medicare, but the Employee is still a full-time active Employee, this event is not a COBRA Qualifying Event since Medicare entitlement alone does not cause a loss of coverage. If the covered Employee voluntarily terminates employment after the Medicare entitlement date, the loss of coverage triggers a potential 18-month COBRA continuation period for all Qualified Beneficiaries. While the covered Employee is only entitled to 18 months of COBRA Continuation Coverage, the other Qualified Beneficiaries (spouse and/or Dependent children) are entitled to 18 months or 36 months, measured from the date of the Employee's Medicare entitlement, whichever is greater.

Note: Medicare entitlement means that You are eligible for and enrolled in Medicare.

Disability extension of 18-month period of COBRA Continuation Coverage

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and You notify the Plan Administrator as set forth herein, 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 COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed 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 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
AHS MANAGEMENT COMPANY, INC.
340 Seven Springs Way Ste 100
Brentwood, TN 37027
(615) 296-3000

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If Your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in Your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. 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 (in certain circumstances), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description

of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
AHS MANAGEMENT COMPANY, INC.
340 Seven Springs Way Ste 100
Brentwood, TN 37027
(615) 296-3000

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?
COBRA Continuation Coverage will end before the end of the maximum period on the earliest of the following dates:

- The date Your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary 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
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary 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; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?
Once COBRA Continuation Coverage is elected, You must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

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, Children's Health Insurance Program (CHIP) 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 many of these options at www.HealthCare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if You don't enroll in Medicare Part A or B when You are first eligible because You are still employed, after the Medicare initial enrollment period, You have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after Your employment ends; or

- The month after group health plan coverage based on current employment ends.

If You don't enroll in Medicare and elect COBRA continuation coverage instead, You may have to pay a Part B late enrollment penalty and You may have a gap in coverage if You decide You want Part B later. If You elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate Your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if You enroll in the other part of Medicare after the date of the election of COBRA coverage.

If You are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if You are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-You.

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

Plan Administrator
AHS MANAGEMENT COMPANY, INC.
340 Seven Springs Way Ste 100
Brentwood, TN 37027
(615) 296-3000

For more information about Your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, 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) in Your area or visit www.dol.gov/agencies/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.

Current Addresses
To protect Your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

STATEMENT OF ERISA RIGHTS

As a Plan Participant in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

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, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy 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, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

To the extent required by ERISA to be prepared by the Plan, receive a summary of the Plan's annual financial report. Plan Administrators are required by law to furnish Participants in certain plans with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for Yourself, Your spouse and/or Your Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or Your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing Your COBRA Continuation Coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Welfare Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan Participants and beneficiaries. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit under the Plan 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 Document or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a Claim for benefits which is denied or ignored, in whole or in part, You may file suit in a State or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a 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 should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your Claim or suit is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If You have any questions about Your 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 Office of Outreach, Education, and Assistance, 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.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)
PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

The Plan will not use or disclose Protected Health Information ("PHI") except as permitted by this section or as otherwise permitted or required by law, including but not limited to the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Rule"), as may be amended from time to time. Nothing in this section shall be construed to prohibit the Plan Sponsor's receipt of "summary health information," as described in the HIPAA Privacy Rule, for certain Plan Sponsor-related purposes, including obtaining premium bids for health insurance, making Plan design and funding decisions, and modifying, amending, or terminating the Plan.

PLAN SPONSOR'S OBLIGATIONS REGARDING PROTECTED HEALTH INFORMATION (PHI)

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor to the Plan that the Plan has been amended to provide for the Plan Sponsor's receipt of PHI and that the Plan Sponsor agrees to comply with the following provisions:

1. The Plan Sponsor may use or disclose PHI for Plan enrollment purposes, including information as to whether an individual is enrolled in the Plan.

2. The Plan Sponsor may use or disclose PHI for Plan administration functions, including for payment or health care operations purposes (as those terms are defined by the HIPAA Privacy Rule), and including quality assurance, Claims processing, auditing, and monitoring of the Plan.

3. The Plan Sponsor may not use or further disclose PHI other than as permitted or required by the Plan Document or as required by law.

4. The Plan Sponsor must ensure that any agents, including subcontractors, 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 regard to the PHI.

5. The Plan Sponsor may not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or other Employee Benefit Plan of the Plan Sponsor.

6. The Plan Sponsor must report to the Plan any use or disclosure of the PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for under the terms of the Plan.

7. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan Document was amended as required by the HIPAA Privacy Rule.

8. The Plan Sponsor must make PHI available for access in accordance with the HIPAA Privacy Standards regarding an individual's right to access his/her PHI.

9. The Plan Sponsor must make PHI available for amendment and, if required by the HIPAA Privacy Standards, incorporate any amendment made to PHI in accordance with the HIPAA Privacy Standards regarding an individual's right to have his PHI amended.

10. The Plan Sponsor must make available information necessary to provide an accounting to an individual in accordance with the HIPAA Privacy Standards regarding an individual's right to receive an accounting of disclosures of his/her PHI.

11. The Plan Sponsor must make internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Standards.

12. The Plan Sponsor must, 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 information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor must limit further

uses and disclosures to those purposes that make the return or destruction not feasible.

13. The Plan Sponsor must ensure adequate separation between the Plan and the Plan Sponsor by restricting access to and use of the PHI to only those Employees of the Plan Sponsor with responsibilities related to the administrative functions the Plan Sponsor performs for the Plan, as such Employees may be designated or identified, by name, job title, or classification, from time to time.

14. The Plan Sponsor must ensure adequate separation between the Plan and the Plan Sponsor by maintaining a procedure for resolving any issues of noncompliance with provisions of the Plan Document by persons described in paragraph 13 above through training, sanctions, and other disciplinary action, as necessary.

15. The Plan Sponsor shall not directly or indirectly receive remuneration in exchange for any PHI without valid authorization that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving PHI of the individual making authorization, except as otherwise allowed under the American Recovery and Reinvestment Act.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI)

The Plan will not use or disclose ePHI except as permitted by this section or as otherwise permitted or required by law, including but not limited to the requirements of 45 C.F.R. Sections 164.314(b)(1) and (2) and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 of the Security Standards of the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Security Standards"), as they may be amended from time to time. Nothing in this section shall be construed to prohibit the Plan Sponsor's receipt of "summary health information," as described in the HIPAA Security Standards, for certain Plan Sponsor-related purposes, including obtaining premium bids for health insurance, making Plan design and funding decisions, and modifying, amending, or terminating the Plan.

PLAN SPONSOR'S OBLIGATIONS REGARDING ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI)

The Plan will disclose ePHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan has been amended to provide for the Plan Sponsor's receipt of ePHI and that the Plan Sponsor agrees to comply with the following provisions:

1. The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.

2. The Plan Sponsor shall ensure the adequate separation that is required by 45 C.F.R. Section 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures.

3. The Plan Sponsor shall ensure any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect such information.

4. The Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

    a. The Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's ePHI.

    b. The Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis semi-annually, or more frequently upon the Plan's request.

BREACH AND SECURITY INCIDENTS

The Health Information Technology for Economic and Clinical Health Act (HITECH) of the American Recovery and Reinvestment Act of 2009 (ARRA) imposes notification in the event of a Breach of unsecured PHI.

The Plan Sponsor will report to the Privacy Official of the Plan any use or disclosure of PHI not permitted by HIPAA,

along with any Breach of unsecured PHI. The Plan Sponsor will treat the Breach as being discovered in accordance with HIPAA's requirements. The Plan Sponsor will make the report to the Privacy Official not more than 30 calendar days after the Plan Sponsor learns of such non-permitted use or disclosure. If a delay is requested by a law enforcement official in accordance with 45 C.F.R. § 164.412, the Plan Sponsor may delay notifying the Privacy Official for the time period specified by such regulation. The Plan Sponsor's report will at least:

1. Identify the nature of the Breach or other non-permitted use or disclosure, which will include a brief description of what happened, including the date of any Breach and the date of the discovery of any Breach;

2. Identify PHI that was subject to the non-permitted use or disclosure or Breach (such as whether full name, Social Security number, date of birth, home address, account number, or other information was involved) on an individual-by-individual basis;

3. Identify who made the non-permitted use or disclosure and who received the non-permitted disclosure;

4. Identify what corrective or investigational action the Plan Sponsor took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects and to protect against any further Breaches;

5. Identify what steps the individuals who were subject to a Breach should take to protect themselves; and

6. Provide such other information, including a written report, as the Privacy Official may reasonably request.

The Plan Sponsor will report to the Privacy Official within 30 calendar days any attempted or successful: a) unauthorized access, use, disclosure, modification, or destruction of ePHI; and b) interference with the Plan Sponsor's system operations in the Plan Sponsor's information systems, of which the Plan Sponsor becomes aware. The Plan Sponsor will make this report upon the Privacy Official's request, except if any such Security Incident resulted in a disclosure or Breach of PHI or ePHI not permitted by the HITECH Act, the Plan Sponsor will make the report in accordance with the above.

GENERAL PROVISIONS

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

MISSTATEMENT OF AGE

If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverages or amounts of benefits, or both, for which the person is covered shall be adjusted in accordance with the Plan Participant's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Benefits will be adjusted following the date of the discovery of such misstatement.

FUNDING

For Employee Coverage: The Employer shares the cost of Employee coverage under this Plan with the covered Employee.

For Dependent Coverage: The Employee pays the entire cost of Dependent coverage under the Plan.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

WAIVER OR ESTOPPEL

No term, condition or provision of the Plan shall be waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written direction of the Plan Administrator. No such waiver shall be deemed a continuing waiver unless specifically stated. Each 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 that specifically waived.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance or, where permitted and applicable, any other alternative form of Workers' Compensation benefits.

UNCASHED CHECKS

A benefit payment made via check must be cashed or deposited within one year after the date the check was issued or it will be treated as a forfeiture and may be used by the Plan Administrator to pay Plan benefits or offset Plan administrative expenses.

CONFORMITY WITH LAW

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.

FRAUD

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

Plan Participant in the Plan;

2. Attempting to file a Claim for a Plan Participant for services that were not rendered or drugs or other items that 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.

In addition to being considered fraud on the Plan and an intentional misrepresentation, enrolling ineligible dependents or maintaining coverage for a person who no longer satisfies the dependent eligibility rules violates company policy. If the company determines that an ineligible dependent has been enrolled, coverage may be canceled retroactively. The company reserves the right to recover any and all benefit payments made for services received by ineligible dependents and to terminate a Plan Participant's employment, if applicable.

ASSIGNMENT

A Plan Participant may not assign or transfer any benefits or rights that arise under the Plan or applicable law to any other person, including a healthcare provider, and any purported assignment or transfer is void. This includes (but is not limited to) an attempted assignment or transfer of claims for payment of benefits, breach of fiduciary duty, penalties or any other claim or remedy. For convenience, the Plan may pay any undisputed benefit directly to the healthcare provider, but this is not a waiver of this anti-assignment provision and does not make the healthcare provider an assignee or confer any other rights on the provider. Similarly, the Plan recognizes an authorized representative for purposes of the Plan's claims and appeal procedures, but the authorized representative is not an assignee and has no derivative rights with respect to the claim. However, this anti-assignment provision will not apply (1) to an assignment of a Plan Participant's rights to the Plan or the Plan Administrator, or (2) to the extent required under Medicaid laws.

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan reserves the right to allocate the deductible amount to any Covered Medical Services and to apportion the benefits to the Plan Participant and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Plan Participant and all assignees.

FACILITY OF PAYMENT

If a Claimant is a minor or is physically or mentally incapable of giving a valid release for payment, the Claims Administrator, at its option, may make payment to a party who has assumed responsibility for the care of such person. Such payments will be made until Claim is made by a guardian. If a Claimant dies while benefits remain unpaid, benefits will be paid at the Claim Administrator's option to:

1. The person or institution on whose charges Claim is based; or

2. A surviving relative (wife, husband, mother, father, Child or Children, brother or brothers, sister or sisters).

Such payment will release the Plan Administrator and Claims Administrator of all further liability to the extent of payment.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY

A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

The Plan Sponsor reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part at any time and for any reason. This includes amending the benefits under the Plan or the Trust agreement (if any). Subject to the requirements of ERISA §402 (if applicable), in the event of a termination or partial termination of the Plan or Trust (if applicable), the Plan by action of the Plan Administrator, the Board of Directors, or other authorized committee thereof, shall direct the disposition of Plan assets, including assets held in a Trust, if any, which may include transfer of such assets to another employee benefit plan or trust maintained by the Employer.

DEFINITIONS

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

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

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer.

Affiliated Company means a corporation, business, partnership or sole proprietorship that is under common control of the named Employer, but who operate under their own Tax ID.

Allowable Charge means the amount for a treatment, service or supply that is the negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement.

For Covered Medical Services rendered by a Physician, Hospital or ancillary provider in a geographic area where applicable law or a governmental authority directs the amount to be paid, the Allowable Charge will mean the amount established by applicable law or governmental authority for the Covered Medical Service.

In the absence of such network arrangement, negotiated arrangement, controlling law or governmental directive that establishes the amount to be paid, the Allowable Charge will mean:

i. the actual billed charges for the Covered Medical Services;
ii. the Allowable Claim Limit;
iii. the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in the geographical area; or
iv. a reasonable amount established solely and exclusively by the Plan Administrator or its designee.

In the event the Non-Network Provider disputes the Plan's Allowable Charge for any claim subject to the No Surprises Act (NSA) through the Independent Dispute Resolution (IDR) process, the Allowable Charge may be determined by a Certified IDR Entity.

Allowable Claim Limits mean the charges for services and supplies, listed and included as Covered Medical Services under the Plan, which are Medically Necessary for the care and treatment of a covered Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Please refer to the section, "Claim Review and Audit Program" for additional information regarding Allowable Claim Limits.

Ancillary Services mean incidental services that assist a medical procedure, but are not essential to the accomplishment of the medical procedure (i.e., laboratory testing).

Applied Behavior Analysis (ABA) Therapy is a scientific approach that applies the understanding of how behavior works to real situations with the goal of increasing behaviors that are helpful, and decreasing behaviors that are harmful or that affect learning. ABA Therapy involves many techniques for understanding and changing behavior. ABA Therapy programs can help to increase language and communication skills; improve attention, social skills, and academics; and decrease problem behaviors.

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).

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

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and

have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Certified Independent Dispute Resolution (IDR) Entity means an entity responsible for conducting determinations under the No Surprises Act (NSA) that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Complications of Pregnancy are determined as follows:

These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions **are not** considered a Complication of Pregnancy: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning sickness; or like conditions that are not medically termed as Complications of Pregnancy.

Congenital Anomaly means a physical, metabolic or anatomic deviation from the normal pattern of development that is apparent at birth or detected during the first year of life.

Covered Medical Service(s) means those Medically Necessary services or supplies that are covered under this Plan, Preventive Care Services as determined by the current U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations, and other routine care services specifically stated as an eligible expense under this Plan.

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

Direct Agreement means a complete agreement between a Directly Contracted Provider and Imagine360 or the Plan Sponsor which contains the terms and conditions under which the Plan Participant may access discounted fees and/or negotiated or scheduled reimbursement rates which the Plan adopts as Allowable Claims Limits for claims submitted by a Directly Contracted Provider.

Directly Contracted Provider means a medical provider, supplemental benefit provider and/or supplemental network partner which has entered into a Direct Agreement with Imagine360, including any affiliates, or the Plan Sponsor to provide certain medical services to Plan Participants at agreed upon Allowable Claim Limits.

Donor means one who furnishes blood, tissue, or an organ to be used in the Plan Participant.

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

Emergency Services means the following:

1. An appropriate 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 or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Medical Emergency; and

2. Within the capabilities of the staff and facilities available at the Hospital (including Hospital outpatient

department that provides emergency services) or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to a Medical Emergency, Emergency Services shall also include an item or service provided by a Non-Network provider (regardless of the department of the Hospital in which items or services are furnished) after the Plan Participant is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the provider determines that the Plan Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Plan Participant is in a condition to, and in fact does, give informed consent to the provider to be treated as a Non-Network Provider.

Employee means a person who is classified by his Employer, including any Affiliated Company Employers, as an Active, common law Employee.

Employer is AHS MANAGEMENT COMPANY, INC. and Affiliated Companies, that together comprise a controlled group of companies as defined under IRC §§ 414(b) & (c).

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

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

The Plan Administrator must make an independent evaluation of the Experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

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; or

2. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating Facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

3. except as provided under the Clinical Trial benefit in the Clinical Trials Benefit section, if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

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

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

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

Facility means a healthcare institution which meets all applicable state or local licensure requirements. For the purposes of the Claim Review and Audit Program, Facility includes, but is not limited to, Hospitals, emergency, rehabilitation and Skilled Nursing Facilities, Outpatient Surgical Centers, laboratories, x-ray, MRI or other CT facilities, and any other health care Facility.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Fiduciary is the entity that exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

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

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

Habilitation Services mean a service 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.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

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

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed Facility, home care, and family counseling during the bereavement period.

Hospice Unit is a Facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and that fully meets these tests: it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour nursing services by or under the supervision of registered nurses (R.N.s); and it is operated

continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A Facility operating legally as a psychiatric Hospital or residential treatment Facility for mental health and licensed as such by the state in which the Facility operates.

- A Facility operating primarily for the treatment of Substance Abuse if it has received accreditation from Commission of Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC), or if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

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

Incurred means 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, expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

Independent Freestanding Emergency Department means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services. Independent Freestanding Emergency Departments do not include Urgent Care Centers or Clinics.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

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

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the Lifetime of the Plan Participant.

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

- Provides for Child support with respect to a Plan Participant's Child or directs the Plan Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
- 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 Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary or Medical Necessity care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

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

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

Morbid Obesity means a diagnosed condition in which the body weight of an individual is the greater of 100 pounds or 100% over the medically recommended weight for a person of the same height, age and mobility and by a BMI (body mass index) greater than 40 (in accordance with Utilization Review's criteria for morbid or severe Obesity).

Network Provider/Network Facility means a healthcare institution or healthcare provider who have by contract agreed to provide services at discounted reimbursement rates. A single direct contract or case agreement between a health care Facility or healthcare provider and a Plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

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

Non-Network Provider/Non-Network Facility means a healthcare institution or healthcare provider who do not have a contractual relationship with the Plan or issuer, respectively, regarding reimbursement of items or services they provide.

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

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

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

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

Plan means ARDENT HEALTH SERVICES GROUP HEALTH PLAN, which is a benefits plan for certain Employees of AHS MANAGEMENT COMPANY, INC. and its Affiliated Companies, as described in this document.

Plan Amendment means a formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Sponsor.

Plan of Care is a written plan that describes the services being provided and any applicable short term and long term goals, specific treatment techniques, anticipated frequency and duration of treatment, and/or treatment protocol for the Plan Participant's specific condition. The Plan of Care must be written or approved by a Physician and updated as the Plan Participant's condition changes.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

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

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician.

Qualified Individual means 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.

Qualifying Payment Amount (QPA) means the median of the contracted rates recognized by the Plan or recognized by all Plans serviced by the Plan's Third-Party Administrator (if calculated by the Third-Party Administrator), for the same or a similar item or service provided by a provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a QPA, said amount will be determined by referencing an applicable state all-payer claims database or any eligible third-party database in accordance with applicable law.

Recognized Amount, except for Non-Network Provider air ambulance services, means an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable, and for Non-Network Provider air ambulance services, the Recognized Amount shall mean the lesser of a provider's billed charge or the Qualifying Payment Amount.

Rehabilitation Facility means a legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative inpatient care, and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, Custodial Care, ambulatory, or part-time care services, or an institution which primarily provides treatment of Mental Disorders or Chemical Dependency, except if such Facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of mental conditions or Drug addiction or Chemical Dependency in the jurisdiction where it is located, or it is accredited as such a Facility by the Joint Commission on the Accreditation of Health Care Organizations, or the Commission on the Accreditation of Rehabilitation Facilities.

Residential Treatment Center means a Facility that provides 24-hour treatment for chemical dependency, drug and substance abuse or mental health problems on an inpatient basis. It must provide at least the following: Room and Board; medical services; nursing and dietary services; patient diagnosis, assessment and treatment; individual, Family and group counseling; and educational and support services. A Residential Treatment Center is recognized if it is accredited for its stated purpose by the Joint Commission on Accreditation of Hospitals and carries out its stated purpose in compliance with all relevant State and local laws.

Room and Board means all charges, by whatever name called, which are made by a Hospital, Hospice, Skilled Nursing Facility, Rehabilitation Facility or other covered Facilities as a condition of inpatient confinement as a bed patient.

Routine Patient Cost(s) means 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.

Skilled Nursing Facility is a Facility that fully meets all of the following:

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

2. Its services are provided for compensation and under the full-time supervision of a Physician.

3. It provides 24-hour nursing services by licensed nurses, under the direction of a full-time registered nurse.

4. It maintains a complete medical record on each patient.

5. It has an effective utilization review plan.

6. It is not, other than incidentally, a place for rest, the aged, Custodial or educational care.

7. It is approved and licensed by Medicare.

This term also applies to charges Incurred in a Facility referring to itself as an extended care Facility, convalescent nursing home, rehabilitation Hospital, long-term acute care Facility or any other similar nomenclature.

Sleep Disorder means medical/psychological condition that disrupts the patient's sleep on a chronic basis.

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

You / Your means the Employee and, when applicable, covered Dependents.

Plan Name:	**ARDENT HEALTH SERVICES GROUP HEALTH PLAN**
Effective:	**January 1, 2020**
Restated:	**January 1, 2026**

I, _____, certify that I am the _____
Name Title

of the **Plan Administrator** for the above named Plan, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the terms described herein and am hereby authorizing the implementation of the restated Plan Document as of the restatement date noted above.

Signature: Cassandra Grissett-Williams

Print Name: Cassandra Grissett-Williams

Date: February 4, 2026