Summary Plan Description

Eastern Catholic Benefit Plan
Employee Group Medical Plan

Group No: 001WC7

Effective: January 1, 2021

RECEIPT OF SUMMARY PLAN DESCRIPTION

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

I further understand that my rights and eligibility under the Special Enrollment Periods and Elections are outlined within the pages of this Summary Plan Description. By my following signature, I acknowledge receipt of the Summary Plan Description and that I am aware of my rights under the Special Enrollment Periods and Elections.

I acknowledge that this Summary Plan Description booklet only applies to the medical and prescription drug benefits offered under the Plan and that this Summary Plan Description booklet does not apply to any other benefits (e.g., dental, vision, etc.) offered under the Plan.

Metropolitan Archdiocese of Pittsburgh, Byzantine Rite

William C. Skurla

Employee Name (Please Print)

William C Skurla

Employee Signature

July 22, 2021

Date

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I. ESTABLISHMENT OF PLAN

THIS SUMMARY PLAN DESCRIPTION sets forth the medical and prescription drug benefits under the Plan (defined below) effective as of January 1, 2021.

A. Description of Plan

The Metropolitan Archdiocese of Pittsburgh sponsors the group health plan known as the Eastern Catholic Benefit Plan (the "Plan"). The Plan is a self-funded church plan for employers associated with the Catholic Church by providing medical benefits to eligible Employees (and their Eligible Dependents) for treatment of covered Illnesses or Injuries. As such, the benefits are directly funded through and provided by your Employer. Your Employer has established a trust to hold funds to pay some benefits under the Plan. Some benefits may be provided through insurance contracts, either through the Trust or otherwise. To the extent that any benefits are not provided through the Trust or through insurance contracts outside the Trust, they are paid from your Employer's general assets. Please note that participant benefit accounts under the Plan, whether in the Trust or not, are bookkeeping entries. No interest is paid on or credited to any benefit account and participants have no access to funds in the accounts except as provided in the Plan. Health Plans, Inc. is not the issuer, insurer, or provider of these benefits.

This Plan is intended to be a "church plan" within the meaning of section 3(33) of the Employee Retirement Income Security Act of 1974 ("ERISA"), for which no election has been made to be subject to ERISA. The Plan should be construed consistent with that intent. It is understood that the Plan works within the framework of the tenets of the Catholic Church. It is for this reason the Plan does not provide benefits for services inconsistent with the position of the Catholic Church; such as, contraception, sterilization, abortion, etc.

B. Effective Date

The Summary Plan Description as applicable to the medical and prescription drug benefits as described herein is effective as of January 1, 2021. The following is a summary of some of the principal features of the Plan's medical and prescription drug benefits. We urge you to read this "Summary Plan Description" carefully. The Summary Plan Description is meant to summarize the Plan in easy-to-understand language. However, in the event of any ambiguity or any inconsistency between this Summary Plan Description and any formal Plan documents or trust agreements, the Plan documents and trust agreements will control. If anything in this Summary Plan Description is not clear to you, or if you have any questions about Plan benefits or Plan claims procedures, please contact the Plan Administrator.

When this Summary Plan Description uses the term "Plan Sponsor", it is referring to the Metropolitan Archdiocese of Pittsburgh, Byzantine Rite, which sponsors the Plan. When this Summary Plan Description uses the term "Employer", it is referring to all of the Plan's participating Employers, which, effective as of January 1, 2021 includes the Plan Sponsor and the Byzantine Catholic Eparchy of Parma, Byzantine Catholic Eparchy of Passaic, Diocese of Newton for the Melkites and Eparchy of Our Lady of Lebanon of Los Angeles. To determine whether your employer is a participating Employer in the Plan on any given date, contact the Plan Administrator at the address provided later in this Summary Plan Description.

Important Notice: To obtain a list of In-Network Providers under this Plan, please visit www.healthplansinc.com/members/Benefits.aspx to search the online provider directory or call the Health Plans, Inc. Customer Service Department at (800) 532-7575 for additional information.

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

II. GENERAL INFORMATION

Plan Name:	Eastern Catholic Benefit Plan
Effective Date:	January 1, 2021
Plan Sponsor:	Metropolitan Archdiocese of Pittsburgh, Byzantine Rite 66 Riverview Avenue Pittsburgh, PA 15214 (412) 231-4000
Participating Employers:	Metropolitan Archeparchy Byzantine Catholic Eparchy of Parma Byzantine Catholic Eparchy of Passaic Diocese of Newton for the Melkites Eparchy of Our Lady of Lebanon of Los Angeles
Employer Identification Number:	25-1044086
Group Number:	001WC7
Plan Administrator:	The Administration Committee of the Eastern Catholic Benefit Plan
Plan Trust:	Eastern Catholic Benefit Trust
Trustees of the Plan	Most Reverend William C. Skurla, D.D. Reverend Albert Constantine Robert J. Shaloub Martin Kopmeyer
Claim Administrator:	Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 https://www.healthplansinc.com (800) 532-7575
Prescription Benefit Manager:	Southern Scripts, LLC 407 Bienville Street Natchitoches, LA 71457 (800) 710-9341

Utilization Management Services:	Precertification is provided by the Cigna Medical Management Program. Call Health Plans, Inc.'s Customer Service Team at (800) 532-7575 which will transfer the call to CIGNA.
Case Management Services:	MedWatch, LLC P.O. Box 952679 Lake Mary, FL 32795-2679 (800) 432-8421
Agent for Service of Legal Process:	Employer (see above) or the Trustee(s)
Plan Year Ends:	December 31st
Fiscal Year Ends:	December 31st
Loss of Benefits:	The Employer may terminate the Plan at any time or change the provisions of the Plan by a written instrument signed by a duly authorized officer of the Employer. An Employee's consent is not required to terminate or change the Plan. Coverage ends on the earlier of the last day of the month in which an Employee terminates employment or otherwise loses eligibility for coverage, or on the first day of the period in which a Covered Person fails to make any required contributions, if applicable. In general, coverage may not be retroactively terminated under this Plan, except in cases of: a) fraud or intentional misrepresentation of material fact related to an Employee's or his or her Eligible dependents' coverage under the Plan, or b) failure to notify the Plan about a dependent's loss of eligibility for coverage under the Plan in a timely manner, or c) failure to pay required premiums or contributions in a timely manner. If coverage is retroactively terminated for any of these reasons, an Employee may be responsible for any benefit payments made during the relevant period. For any rescissions (retroactive termination of coverage that is related to fraud or intentional misrepresentation) the Plan Administrator will provide thirty (30) days advance written notice and an Employee will have

the right to appeal the Plan's termination of coverage.

Patient's Duty to Evaluate Need For Care:

If the Covered Person believes he/she needs Emergency Care, he/she should not forego that care because he/she believes it will not be covered by the Plan.

The Employer assumes no responsibility for the medical care reimbursed by the Plan which is provided by any Physician. Each Covered Person should evaluate the quality of care and act accordingly. No Plan provision expressed in this Summary or the Plan documents should be interpreted to restrict the access to or delivery of Medically Necessary services. A Covered Person's decision to forego such care should not be based on his or her interpretation of this Summary Plan Description or the Plan documents.

III. DEFINITIONS

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

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

Allowed Amount – the maximum amount the Plan will pay an Out-of-Network Provider for Covered Services minus any applicable Coinsurance, Co-payment or Deductible a Covered Person may be responsible for under the Plan. Covered Persons may be responsible for paying the balance of these claims after the Plan pays its portion, if any.

Out-of-Network non-Emergency Care

If non-Emergency Care is received from an Out-of-Network Provider, the Allowed Amount is defined as follows:

The Allowed Amount is an amount that is consistent with historically accepted reimbursements, commercial pricing benchmarks, accepted Medicare rates, preferred provider contractual reimbursements and geographic adjustments

Out-of-Network Emergency Care

If Emergency Care is received in the emergency department of an Out-of-Network Hospital, the Plan will cover the services at the In-Network Deductible, Co-payment and Coinsurance levels, as applicable, and the Out-of-Network Provider will be paid an Allowed Amount defined as an amount based on either: i) a discount agreement; ii) a provider network rate; or iii) a negotiated amount. If the claim cannot be priced at one of the foregoing amounts, the Allowed Amount will be paid at billed charges.

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

(1) Federally funded or approved

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

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

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

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

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

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

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

Covered Person – an Employee or Dependent eligible for benefits and enrolled under this Plan

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

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

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

Eligible Dependent –

(1) An Employee's opposite-sex Spouse

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

Divorced Spouses are ***not eligible*** for coverage under this Plan even if a court judgment governing the terms of the divorce, requires the Employee to provide health coverage for the former Spouse. Eligibility in the Plan will be terminated.

(2) An Employee's child under age 26

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

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

For the purposes of subsections (2) and (3) above, "Employee's child" means:

(a) Natural child of the Employee;

(b) Stepchild by marriage;

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

Eligibility Due to Adoption or Placement for Adoption

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

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

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

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

(e) Child who is the subject of a Medical Child Support Order (as defined herein)

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

Employees are obligated to inform the Plan Administrator of any change in a dependent's eligibility status within 30 days of such change. In the event that an ineligible dependent is found to have received benefits under this Plan, the Employee will be responsible for any benefit payments made on that dependent's behalf.

Emergency Care – care administered in a Hospital, clinic, or Physician's office for a Medical Emergency; Emergency Care does not include ambulance service to the facility where treatment is received

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

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

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

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

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

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

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

Reliable evidence will mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, new technology, procedure or supply; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, new technology, procedure or supply.

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

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

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

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

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

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

(4) It has an administrator

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

Hospital – a licensed facility which:

(1) Furnishes room and board;

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

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

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

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

The term "Hospital" will include a facility specializing in the care and treatment for rehabilitation and mental or emotional Illness, disorder or disturbance, which would qualify under this definition as a Hospital; or a residential treatment facility specializing in the care and treatment of mental illness, alcoholism, drug addiction or chemical dependency, provided such facility is duly licensed, if licensing is required by law in the jurisdiction where it is located, or provided such facility is accredited by the Joint Commission on Accreditation of Health Care Organizations and the Commission on Accreditation of Rehabilitation Facilities

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

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

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

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

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

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

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

(3) Provides pre-death and bereavement counseling;

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

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

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

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

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

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

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

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

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

(3) Not Experimental or Investigational; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Skilled Nursing Facility – a licensed facility which:

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

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

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

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

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

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

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

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

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

the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant

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

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

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

IV. SCHEDULE OF MEDICAL BENEFITS

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

Precertification

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

Call (800) 532-7575 prior to receiving services shown as requiring precertification to confirm the Medical Necessity of the proposed services.

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

IMPORTANT
Precertification for inpatient hospitalization is always required.

If a Covered Person is scheduled to be admitted to a Hospital, he or she must have the hospitalization precertified under the Plan prior to the date of admission or within two business days of admission in the case of emergency admissions.

Failure to obtain precertification for inpatient services and certain outpatient procedures may result in a reduction in benefits. Any reduction in benefits for inpatient services cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan.

Other Questions Regarding Eligibility and Benefits

Please contact the Claims Administrator at (800) 532-7575 if you have questions about Plan benefits or eligibility for covered dependents.

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

PLAN 1

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY SOUTHERN SCRIPTS	
Prescription Drug Expense & Mail Order Option Note: Prescription drug Co-payments accumulate toward the Out-of-Pocket Maximum (shown below). Once the Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% for the balance of the Calendar Year. Tobacco cessations products are covered at 100% Substitution of a generic equivalent medication is required; if a Covered Person requests the brand name medication be filled, the Covered Person pays the difference between the brand and generic drug, in addition to the brand name Co-payment, when a generic drug is available. Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Manager.	**Retail Card Program – You Pay:** (Up to a 31 day supply) $10 Co-payment per generic drug; $20 Co-payment per preferred brand name drug; $40 Co-payment per non-preferred brand name drug; $80 Co-payment per specialty drug **Mail Order Pharmacy – You Pay:** (Up to a 90 day supply) $20 Co-payment per generic drug; $40 Co-payment per preferred brand name drug; $80 Co-payment per non-preferred brand name drug Preventive drugs are covered with no cost-sharing. Contraceptive medications are not covered.
Out-of-Network Pharmacy Coverage	NOT COVERED

PLAN 1

MEDICAL BENEFITS		
BENEFIT LEVELS	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Medical Calendar Year Deductible	Single Plan (Employee only): NONE Family Plan (Employee & family): NONE	Single Plan (Employee only): $250 Family Plan (Employee & family): $250 per person, up to $500 per family
Note: The Out-of-Network Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the Out-of-Network individual Deductible, claims will be paid for that individual. Otherwise, the entire Out-of-Network family Deductible must be satisfied before claims will be paid for any family members. The Out-of-Network family Deductible may be met by any combination of family members.		
Reimbursement Percentage ("Coinsurance")	100% of the Contracted Rate (after Deductible; unless otherwise stated)	80% of the Allowed Amount (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Calendar Year
Calendar Year Out-of-Pocket Maximums (Including all applicable Co-payments, Calendar Year Deductible and Coinsurance, including those for prescription drugs)	Single Plan (Employee only):$6,600 Family Plan (Employee & family): $6,600 per person, up to $13,200 per family	Single Plan (Employee only):$13,200 Family Plan (Employee & family): $13,200 per person, up to $26,400 per family
Note: The Family Plan contains both an individual Out-of-Pocket Maximums and a family Out-of-Pocket Maximums. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximums is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximums may be met by any combination of family members.		
The In-Network Provider and Out-of-Network Out-of-Pocket Maximums are separate and do not accumulate. Eligible expenses which track toward the In-Network Provider Out-of-Pocket Maximums will not be credited toward the satisfaction of the Out-of-Network Deductible and Out-of-Pocket Maximums and vice versa. **The following expenses are excluded from the Out-of-Pocket Maximum(s):** • Precertification penalties ***The Covered Person is also responsible to pay any amount above the Allowed Amount when services are rendered by an Out-of-Network Provider.***		

PLAN 1

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.		
****Routine Physical Exams** (Including routine and travel immunizations and flu shots)	100%	80% Allowed Amount (after Deductible)
****Routine Well Child Care** (Including screenings, routine and travel immunizations and flu shots)	100%	80% Allowed Amount (after Deductible)
****Fluoride Varnish** (Up to age 6) Up to four (4)* varnish treatments per person, per Calendar Year	100%	80% Allowed Amount (after Deductible)
****Breastfeeding Support, Supplies and Counseling** (During pregnancy and/or in the postpartum period and rental or purchase of breastfeeding equipment) <u>Breast Pump Limits</u>: • Hospital Grade Breast Pumps: rental covered up to 3 months; *precertification required* for rental in excess of 3 months • Electric Breast Pumps: rent or purchase, whichever is less; • Manual Breast Pumps: purchase	100%	80% Allowed Amount (after Deductible)
****Routine Gynecological/ Obstetrical Care** (Including preconception and prenatal services)	100%	80% Allowed Amount (after Deductible)
****Routine Pap Smears**	100%	80% Allowed Amount (after Deductible)
**** Breast Cancer Screening including Routine Mammograms and BRCA testing** (Age 40 and older)	100%	80% Allowed Amount (after Deductible)
One Baseline Mammogram (Age 35 through 39)	100%	80% Allowed Amount (after Deductible)
****Routine Immunizations** (If not billed with an office visit; includes flu shots and travel immunizations)	100%	80% Allowed Amount (after Deductible)

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

PLAN 1

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.		
****Routine Lab, X-rays, and Clinical Tests** (Including those related to maternity care)	100%	80% Allowed Amount (after Deductible)
****Routine Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies** (Age 50 and older)	100%	80% Allowed Amount (after Deductible)
****Lung Cancer Screening, including Low-Dose Computed Tomography (LDCT)** (Age 55 and older) Up to one (1)* per person, per Calendar Year	100%	80% Allowed Amount (after Deductible)
****Nutritional Counseling**	100%	80% Allowed Amount (after Deductible)
****Smoking Cessation Counseling and Intervention** (Including smoking cessation clinics and programs)	100%	80% Allowed Amount (after Deductible)
Routine Prostate Exams and Prostate-Specific Antigen (PSA) Screenings	100%	80% Allowed Amount (after Deductible)
****Abdominal Aortic Aneurysm Screening** (For men age 65 and over) Up to one (1)* per person, per lifetime	100%	80% Allowed Amount (after Deductible)
****Bone Density Screening** • Women age 60 and older • All other Covered Persons	 100% 100%	 80% Allowed Amount (after Deductible) 80% Allowed Amount (after Deductible)

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

PLAN 1

VISION CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Eyewear for Special Conditions (Includes lenses necessary to treat certain medical conditions; *see* Medical Benefits *section for other limitations*)	100%	80% Allowed Amount (after Deductible)
PHYSICIAN SERVICES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Allergy Testing	100%	80% Allowed Amount (after Deductible)
Allergy Treatment	100%	80% Allowed Amount (after Deductible)
Anesthesia (Inpatient/Outpatient)	100%	80% Allowed Amount (after Deductible)
Chiropractic Services *(Precertification required after the first (5)* visits)* Up to 30* visits per person, per Calendar Year	100%	80% Allowed Amount (after Deductible)
Maternity (Employee & Spouse Only) (Includes Physician delivery charges, prenatal and postpartum care) • Prenatal care • Physician delivery charges • Postnatal care	 100% 100% 100%	 90% Allowed Amount (Deductible waived) 80% Allowed Amount (after Deductible) 90% Allowed Amount (Deductible waived)
Physician Hospital Visits	100%	80% Allowed Amount (after Deductible)
Physician Office (Includes all related charges billed at time of visit)	$20 Co-payment per visit, then 100%	80% Allowed Amount (after Deductible)
Second Surgical Opinion	$20 Co-payment per visit, then 100%	80% Allowed Amount (after Deductible)
Surgery (Inpatient)	100%	80% Allowed Amount (after Deductible)
Surgery (Outpatient)	100%	80% Allowed Amount (after Deductible)
Surgery (Physician's office)	$20 Co-payment per visit, then 100%	80% Allowed Amount (after Deductible)

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

PLAN 1

HOSPITAL SERVICES – INPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **<u>Inpatient Hospital Co-payment:</u> A separate $100 Hospital Co-payment will apply to each inpatient admission in an In-Network facility.** **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
Hospital Room & Board *(Precertification required)* Semi-private room or special care unit	$100 Co-payment per admission, then 100%	80% Allowed Amount (after Deductible)
Maternity Services (Employee & Spouse Only) *(Precertification required for stays in excess of 48 hours[vaginal]; 96 hours [cesarean])* Semi-private room or special care unit	$100 Co-payment per admission, then 100%	80% Allowed Amount (after Deductible)
Birthing Center (Employee & Spouse Only)	$100 Co-payment per admission, then 100%	80% Allowed Amount (after Deductible)
Newborn Care (Includes Physician visits & circumcision) Semi-private room or special care unit	100%	80% Allowed Amount (after Deductible)
Organ, Bone Marrow and Stem Cell Transplants *(Precertification required; see* Medical Benefits *section for other limitations*) Semi-private room or special care unit Transportation/food/lodging limits: Lodging: $50 per night per person to a maximum of $100 per night; Overall Maximum is $10,000* per Transplant.	Managed through Cigna's LifeSOURCE Transplant Network®	80% Allowed Amount (after Deductible)
Surgical Facility & Supplies	100%	80% Allowed Amount (after Deductible)
Miscellaneous Hospital Charges	100%	80% Allowed Amount (after Deductible)

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

PLAN 1

HOSPITAL SERVICES – OUTPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
***Precertification for certain outpatient surgical procedures is required*. Failure to obtain precertification for certain outpatient surgical procedures may result in a reduction in benefits.**		
Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.		
Clinic Services (At a Hospital)	100%	80% Allowed Amount (after Deductible)
Emergency Room Expenses (Includes Facility, Lab, X-ray & Physician services) Non-Emergency Use	100% $100 Co-payment per visit, then 100%	100% Allowed Amount (Deductible waived) 80% Allowed Amount (after Deductible)
Outpatient Department	100%	80% Allowed Amount (after Deductible)
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc. *(Precertification required for spinal procedures, and potentially cosmetic procedures)*	100%	80% Allowed Amount (after Deductible)
Preadmission Testing	100%	80% Allowed Amount (after Deductible)
Urgent Care Facility/Walk-In Clinic	$20 Co-payment per visit, then 100%	80% Allowed Amount (after Deductible)

PLAN 1

MENTAL HEALTH/ SUBSTANCE ABUSE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **<u>Inpatient Hospital Co-payment:</u> A separate $100 Hospital Co-payment will apply to each inpatient admission in an In-Network facility.** **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
Inpatient Hospitalization *(Precertification required)*	$100 Co-payment per admission, then 100%	80% Allowed Amount (after Deductible)
Partial Hospitalization/Intensive Outpatient Treatment	100%	80% Allowed Amount (after Deductible)
Inpatient Physician Visit	100%	80% Allowed Amount (after Deductible)
Hospital Clinic Visit	100%	80% Allowed Amount (after Deductible)
Office Visit	$20 Co-payment per visit, then 100%	80% Allowed Amount (after Deductible)

PLAN 1

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Ambulance Services (*See* Medical Benefits *section for limitations*)	100%	100% Allowed Amount (Deductible waived)
Autism Spectrum Disorders Treatment (Includes Applied Behavioral Analysis (ABA); benefit limits do not apply to occupational, physical and speech therapies; *precertification is required* for ABA; s*ee* Medical Benefits *section for limitations*) Note: Screenings are covered under Preventive Care	Benefits are based on services provided	Benefits are based on services provided
Bariatric Surgery (When related to treatment of Morbid Obesity; *see* Medical Benefits *section for other limitations)* Loop gastric bypass, Gastroplasty and Mini gastric bypass are not covered	100%	80% Allowed Amount (after Deductible)
Cardiac Rehabilitation (Phase 1 and 2 only; *see* Medical Benefits *section for other limitations*)	100%	80% Allowed Amount (after Deductible)
Chemotherapy & Radiation Therapy *(Precertification required for Therapeutic Radiology for brachytherapy, proton beam therapy, radiotherapy)*	100%	80% Allowed Amount (after Deductible)
Clinical Trials – Routine Services during Approved Clinical Trials (Limited to routine Covered Services under the Plan, including Hospital visits, laboratory, and imaging services; *see* Medical *Benefits section for other limitations*)	Benefits are based on services provided	Benefits are based on services provided
Dental/Oral Services (Includes excision of impacted wisdom teeth; *see* Medical Benefits *section for other limitations*)	100%	80% Allowed Amount (after Deductible)
Diabetes Self-Management Training and Education	$20 Co-payment per visit, then 100%	80% Allowed Amount (after Deductible)
Diagnostic Imaging (MRI, CT Scan, PET Scan; *precertification required*)	100%	80% Allowed Amount (after Deductible)

PLAN 1

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Diagnostic X-ray and Laboratory (Outpatient)	100%	80% Allowed Amount (after Deductible)
Dialysis/Hemodialysis *(See* Medical Benefits *section for other limitations)*	100%	80% Allowed Amount (after Deductible)
Durable Medical Equipment *(Precertification required for seat lifts, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators including TENS; see* Medical Benefits *section for other limitations)*	100%	80% Allowed Amount (after Deductible)
Growth Hormones *(See* Medical Benefits *section for other limitations)*	100%	80% Allowed Amount (after Deductible)
Home Health Care *(Precertification required for home health care administered by a registered nurse, licensed practical nurse or for aid in the home or home infusion; see* Medical Benefits *section for other limitations; see* Medical Benefits *section for other limitations)*	100%	90% Allowed Amount (after Deductible)
Hospice Care (Inpatient/Outpatient) *(Precertification required for inpatient services; see* Medical Benefits *section for other limitations)*	100%	90% Allowed Amount (after Deductible)
Injectables *(Precertification required for immune globulin, drugs for factor deficiencies, interferon, Rituxan, some chemotherapeutic agents, botox)*	100%	80% Allowed Amount (after Deductible)
Medical and Enteral Formula (Including metabolic formula; *precertification required; see* Medical Benefits *section for other limitations)*	100%	80% Allowed Amount (after Deductible)
Neuromuscular Stimulator Equipment including TENS *(Precertification required)*	100%	80% Allowed Amount (after Deductible)
Occupational Therapy (For treatment due to Illness or Injury; *precertification required after the first five (5)* visits)*	100%	80% Allowed Amount (after Deductible)

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

PLAN 1

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Oral Pharynx Procedures (*Precertification required for uvulectomy, LAUP procedures, palatopharyngoplasty (PPP), uvulopalatopharyngoplasty (UPP)*; s*ee* Medical Benefits *section for other limitations*)	100%	80% Allowed Amount (after Deductible)
Orthotics (Excludes foot orthotics; s*ee* Medical Benefits *section for other limitations*)	100%	80% Allowed Amount (after Deductible)
Pain Management (Inpatient/Outpatient) (Includes payment for Pain Clinic and Pain Management Program fees)	100%	80% Allowed Amount (after Deductible)
Physical Therapy (For treatment due to Illness or Injury; *precertification required after the first five (5)* visits; see* Medical Benefits *section for other limitation*)	100%	80% Allowed Amount (after Deductible)
Podiatry Care *(See* Medical Benefits *section for limitations*)	$20 Co-payment per visit, then 100%	80% Allowed Amount (after Deductible)
Prosthetics *(See* Medical Benefits *section for limitations*)	100%	80% Allowed Amount (after Deductible)
Rehabilitation Hospital *(Precertification required*; s*ee* Medical Benefits *section for other limitations*) Up to 100* days per person, per Calendar Year, combined with Skilled Nursing Facility	$100 Co-payment per admission, then 100%	90% Allowed Amount (after Deductible)
Respiratory Therapy	100%	80% Allowed Amount (after Deductible)
Sleep Management Program *(Precertification required for obstructive sleep apnea, diagnostic or therapeutic sleep studies)*	100%	80% Allowed Amount (after Deductible)
Skilled Nursing Facility/Extended Care Facility *(Precertification required; see* Medical Benefits *section for other limitations*) Up to 100* days per person, per Calendar Year, combined with Rehabilitation Hospital	$100 Co-payment per admission, then 100%	90% Allowed Amount (after Deductible)

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

PLAN 1

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Speech Therapy (For treatment due to Illness or Injury; s*ee* Medical Benefits *section for other limitations)*	100%	80% Allowed Amount (after Deductible)
Telemedicine (Applies to medical and behavioral health services; includes Doctor on Demand; *see* Medical Benefits *section for additional information*)	$20 Co-payment per visit, then 100%	80% Allowed Amount (after Deductible
All other virtual visits with a Provider with whom a Covered Person has established relationship, including, but not limited to Occupational Therapy, Physical Therapy and Speech Therapy	Paid based on services provided	Paid based on services provided
Voluntary Termination of Pregnancy (Covered only in circumstances in which the life of the mother would be put in grave peril by continuing the pregnancy to term)	100%	80% Allowed Amount (after Deductible)

PLAN 2

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY SOUTHERN SCRIPTS	
Prescription Drug Expense & Mail Order Option Note: Prescription drug Co-payments accumulate toward the Out-of-Pocket Maximum (shown below). Once the Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% for the balance of the Calendar Year. Tobacco cessations products are covered at 100% Substitution of a generic equivalent medication is required; if a Covered Person requests the brand name medication be filled, the Covered Person pays the difference between the brand and generic drug, in addition to the brand name Co-payment, when a generic drug is available. Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Manager.	**Retail Card Program – You Pay:** (Up to a 30 day supply) $10 Co-payment per generic drug; $20 Co-payment per preferred brand name drug; $20 Co-payment per non-preferred brand name drug Specialty Drugs are paid as shown above **Mail Order Pharmacy – You Pay:** (Up to a 90 day supply) $20 Co-payment per generic drug; $40 Co-payment per preferred brand name drug; $40 Co-payment per non-preferred brand name drug Preventive drugs are covered with no cost sharing. Contraceptive medications are not covered.
Out-of-Network Pharmacy Coverage	NOT COVERED

PLAN 2

MEDICAL BENEFITS		
BENEFIT LEVELS	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Medical Calendar Year Deductible	Single Plan (Employee only): $250 Family Plan (Employee & family): $250 per person, up to $750 per family	Single Plan (Employee only): $250 Family Plan (Employee & family): $250 per person, up to $750 per family
Note: The Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the individual Deductible, claims will be paid for that individual. Otherwise, the entire family Deductible must be satisfied before claims will be paid for any family members. The family Deductible may be met by any combination of family members.		
Reimbursement Percentage ("Coinsurance")	90% of the Contracted Rate (after Deductible; unless otherwise stated)	70% of the Allowed Amount (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Calendar Year
Calendar Year Out-of-Pocket Maximums (Including all applicable Co-payments, Calendar Year Deductible and Coinsurance, including those for prescription drugs)	Single Plan (Employee only): $1,250 Family Plan (Employee & family): $1,250 per person, up to $3,750 per family	Single Plan (Employee only): $1,250 Family Plan (Employee & family): $1,250 per person, up to $3,750 per family
Note: The Family Plan contains both an individual Out-of-Pocket Maximums and a family Out-of-Pocket Maximums. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximums is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximums may be met by any combination of family members.		
The In-Network Provider and Out-of-Network Deductible and Out-of-Pocket Maximums are separate and do not accumulate. Eligible expenses which track toward the In-Network Provider Deductible and Out-of-Pocket Maximums will not be credited toward the satisfaction of the Out-of-Network Deductible and Out-of-Pocket Maximums and vice versa. **The following expenses are excluded from the Out-of-Pocket Maximum(s):** • Precertification penalties ***The Covered Person is also responsible to pay any amount above the Allowed Amount when services are rendered by an Out-of-Network Provider.***		

PLAN 2

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.		
****Routine Physical Exams** (Including routine and travel immunizations and flu shots)	100% (Deductible waived)	70% Allowed Amount (after Deductible)
****Routine Well Child Care** (Including screenings, routine and travel immunizations and flu shots)	100% (Deductible waived)	70% Allowed Amount (after Deductible)
****Fluoride Varnish** (Up to age 6) Up to four (4)* varnish treatments per person, per Calendar Year	100% (Deductible waived)	70% Allowed Amount (after Deductible)
****Breastfeeding Support, Supplies and Counseling** (During pregnancy and/or in the postpartum period and rental or purchase of breastfeeding equipment) <u>Breast Pump Limits</u>: • Hospital Grade Breast Pumps: rental covered up to 3 months; *precertification required* for rental in excess of 3 months • Electric Breast Pumps: rent or purchase, whichever is less; • Manual Breast Pumps: purchase	100% (Deductible waived)	70% Allowed Amount (after Deductible)
****Routine Gynecological/ Obstetrical Care** (Including preconception and prenatal services)	100% (Deductible waived)	70% Allowed Amount (after Deductible)
****Routine Pap Smears**	100% (Deductible waived)	70% Allowed Amount (after Deductible)
**** Breast Cancer Screening including Routine Mammograms and BRCA testing**	100% (Deductible waived)	70% Allowed Amount (after Deductible)
****Routine Immunizations** (If not billed with an office visit; includes flu shots and travel immunizations)	100% (Deductible waived)	70% Allowed Amount (after Deductible)
****Routine Lab, X-rays, and Clinical Tests** (Including those related to maternity care)	100% (Deductible waived)	70% Allowed Amount (after Deductible)

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

PLAN 2

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.		
****Routine Lab, X-rays, and Clinical Tests** (Including those related to maternity care)	100% (Deductible waived)	70% Allowed Amount (after Deductible)
****Routine Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies** (Age 50 and older)	100% (Deductible waived)	70% Allowed Amount (after Deductible)
****Lung Cancer Screening, including Low-Dose Computed Tomography (LDCT)** (Age 55 and older) Up to one (1)* per person, per Calendar Year	100% (Deductible waived)	70% Allowed Amount (after Deductible)
****Nutritional Counseling**	100% (Deductible waived)	70% Allowed Amount (after Deductible)
****Smoking Cessation Counseling and Intervention** (Including smoking cessation clinics and programs)	100% (Deductible waived)	70% Allowed Amount (after Deductible)
Routine Prostate Exams and Prostate-Specific Antigen (PSA) Screenings	100%	70% Allowed Amount (after Deductible)
****Abdominal Aortic Aneurysm Screening** (For men age 65 and over) Up to one (1)* per person, per lifetime	100% (Deductible waived)	70% Allowed Amount (after Deductible)
****Bone Density Screening** • Women age 60 and older • All other Covered Persons	100% (Deductible waived) 100% (Deductible waived)	70% Allowed Amount (after Deductible) 70% Allowed Amount (after Deductible)

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

PLAN 2

VISION CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Eyewear for Special Conditions (Includes lenses necessary to treat certain medical conditions; *see* Medical Benefits *section for other limitations*)	90% (after Deductible)	70% Allowed Amount (after Deductible)
PHYSICIAN SERVICES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Allergy Testing	90% (after Deductible)	70% Allowed Amount (after Deductible)
Allergy Treatment	$5 Co-payment per visit, then 100% (Deductible waived)	70% Allowed Amount (after Deductible)
Anesthesia (Inpatient/Outpatient)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Chiropractic Services *(Precertification required after the first (5)* visits)* Up to 12* visits per person, per Calendar Year	90% (after Deductible)	70% Allowed Amount (after Deductible)
Maternity (Employee & Spouse Only) (Includes Physician delivery charges, prenatal and postpartum care)		
• Prenatal care	100% (Deductible waived)	70% Allowed Amount (after Deductible)
• Physician delivery charges	90% (after Deductible)	70% Allowed Amount (after Deductible)
• Postnatal care	90% (after Deductible)	70% Allowed Amount (after Deductible)
Physician Hospital Visits	90% (after Deductible)	70% Allowed Amount (after Deductible)
Physician Office (Includes all related charges billed at time of visit)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Second Surgical Opinion	90% (after Deductible)	70% Allowed Amount (after Deductible)
Surgery (Inpatient)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Surgery (Outpatient)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Surgery (Physician's office)	90% (after Deductible)	70% Allowed Amount (after Deductible)

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

PLAN 2

HOSPITAL SERVICES – INPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
Hospital Room & Board *(Precertification required)* Semi-private room or special care unit	90% (after Deductible)	70% Allowed Amount (after Deductible)
Maternity Services (Employee & Spouse Only) *(Precertification required for stays in excess of 48 hours[vaginal]; 96 hours [cesarean])* Semi-private room or special care unit	90% (after Deductible)	70% Allowed Amount (after Deductible)
Birthing Center (Employee & Spouse Only)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Newborn Care (Includes Physician visits & circumcision) Semi-private room or special care unit	90% (after Deductible)	70% Allowed Amount (after Deductible)
Organ, Bone Marrow and Stem Cell Transplants *(Precertification required; see* Medical Benefits *section for other limitations*) Semi-private room or special care unit Transportation/food/lodging limits: Lodging: $50 per night per person to a maximum of $100 per night; Overall Maximum is $10,000* per Transplant.	Managed through Cigna's LifeSOURCE Transplant Network®	70% Allowed Amount (after Deductible)
Surgical Facility & Supplies	90% (after Deductible)	70% Allowed Amount (after Deductible)
Miscellaneous Hospital Charges	90% (after Deductible)	70% Allowed Amount (after Deductible)

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

PLAN 2

HOSPITAL SERVICES – OUTPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
***Precertification for certain outpatient surgical procedures is required*. Failure to obtain precertification for certain outpatient surgical procedures may result in a reduction in benefits.**		
Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.		
Clinic Services (At a Hospital)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Emergency Room Expenses (Includes Facility, Lab, X-ray & Physician services) Non-Emergency Use	90% (after Deductible) 90% (after Deductible)	90% Allowed Amount (after In-Network Deductible) 70% Allowed Amount (after Deductible)
Outpatient Department	90% (after Deductible)	70% Allowed Amount (after Deductible)
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc. *(Precertification required for spinal procedures, and potentially cosmetic procedures)*	90% (after Deductible)	70% Allowed Amount (after Deductible)
Preadmission Testing	90% (after Deductible)	70% Allowed Amount (after Deductible)
Urgent Care Facility/Walk-In Clinic	90% (after Deductible)	70% Allowed Amount (after Deductible)

PLAN 2

MENTAL HEALTH/ SUBSTANCE ABUSE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
Inpatient Hospitalization *(Precertification required)*	90% (after Deductible)	70% Allowed Amount (after Deductible)
Partial Hospitalization/Intensive Outpatient Treatment	90% (after Deductible)	70% Allowed Amount (after Deductible)
Inpatient Physician Visit	90% (after Deductible)	70% Allowed Amount (after Deductible)
Hospital Clinic Visit	90% (after Deductible)	70% Allowed Amount (after Deductible)
Office Visit	90% (after Deductible)	70% Allowed Amount (after Deductible)

PLAN 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Ambulance Services (*See* Medical Benefits *section for limitations*)	90% (after Deductible)	90% Allowed Amount (after In-Network Deductible)
Autism Spectrum Disorders Treatment (Includes Applied Behavioral Analysis (ABA); benefit limits do not apply to occupational, physical and speech therapies; *precertification is required* for ABA; s*ee* Medical Benefits *section for limitations*) Note: Screenings are covered under Preventive Care	Benefits are based on services provided	Benefits are based on services provided
Bariatric Surgery (When related to treatment of Morbid Obesity; *see* Medical Benefits *section for other limitations)* Loop gastric bypass, Gastroplasty and Mini gastric bypass are not covered	90% (after Deductible)	70% Allowed Amount (after Deductible)
Cardiac Rehabilitation (Phase 1 and 2 only; *see* Medical Benefits *section for other limitations*)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Chemotherapy & Radiation Therapy *(Precertification required for Therapeutic Radiology for brachytherapy, proton beam therapy, radiotherapy)*	90% (after Deductible)	70% Allowed Amount (after Deductible)
Clinical Trials – Routine Services during Approved Clinical Trials (Limited to routine Covered Services under the Plan, including Hospital visits, laboratory, and imaging services; *see* Medical *Benefits section for other limitations*)	Benefits are based on services provided	Benefits are based on services provided
Dental/Oral Services (Includes excision of impacted wisdom teeth; *see* Medical Benefits *section for other limitations*)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Diabetes Self-Management Training and Education	90% (after Deductible)	70% Allowed Amount (after Deductible)
Diagnostic Imaging (MRI, CT Scan, PET Scan; *precertification required*)	90% (after Deductible)	70% Allowed Amount (after Deductible)

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

PLAN 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Diagnostic X-ray and Laboratory (Outpatient)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Dialysis/Hemodialysis *(See* Medical Benefits *section for other limitations)*	90% (after Deductible)	70% Allowed Amount (after Deductible)
Durable Medical Equipment *(Precertification required for seat lifts, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators including TENS; see* Medical Benefits *section for other limitations)*	90% (after Deductible)	70% Allowed Amount (after Deductible)
Growth Hormones *(See* Medical Benefits *section for other limitations)*	90% (after Deductible)	70% Allowed Amount (after Deductible)
Home Health Care *(Precertification required for home health care administered by a registered nurse, licensed practical nurse or for aid in the home or home infusion; see* Medical Benefits *section for other limitations; See* Medical Benefits *section for other limitations)* Up to 100* visits per person, per Calendar Year	90% (after Deductible)	70% Allowed Amount (after Deductible)
Hospice Care (Inpatient/Outpatient) *(Precertification required for inpatient services; see* Medical Benefits *section for other limitations)* Up to 180* days per person, per lifetime	90% (after Deductible)	70% Allowed Amount (after Deductible)
Injectables *(Precertification required for* Immune *globulin, drugs for factor deficiencies, interferon, Rituxan, some chemotherapeutic agents, botox)*	90% (after Deductible)	70% Allowed Amount (after Deductible)
Medical and Enteral Formula (Including metabolic formula; *precertification required; see* Medical Benefits *section for other limitations)*	90% (after Deductible)	70% Allowed Amount (after Deductible)
Neuromuscular Stimulator Equipment including TENS *(Precertification required)*	90% (after Deductible)	70% Allowed Amount (after Deductible)

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

PLAN 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Occupational Therapy (For treatment due to Illness or Injury; *precertification required after the first five (5)* visits; see* Medical Benefits *section for other limitation*)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Oral Pharynx Procedures (*Precertification required for uvulectomy, LAUP procedures, palatopharyngoplasty (PPP), uvulopalatopharyngoplasty (UPP)*; s*ee* Medical Benefits *section for other limitations*)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Orthotics (Excludes foot orthotics; s*ee* Medical Benefits *section for other limitations*)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Pain Management (Inpatient/Outpatient) (Includes payment for Pain Clinic and Pain Management Program fees)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Physical Therapy (For treatment due to Illness or Injury; *precertification required after the first five (5)* visits; see* Medical Benefits *section for other limitation*)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Podiatry Care *(See* Medical Benefits *section for limitations*)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Prosthetics *(Precertification required for extremity prosthetic additions; see* Medical Benefits *section for limitations*)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Rehabilitation Hospital *(Precertification required*; s*ee* Medical Benefits *section for other limitations*) Up to 120* days per person, per Calendar Year, combined with Skilled Nursing Facility	90% (after Deductible)	70% Allowed Amount (after Deductible)
Respiratory Therapy	90% (after Deductible)	70% Allowed Amount (after Deductible)
Sleep Management Program *(Precertification required for obstructive sleep apnea, diagnostic or therapeutic sleep studies)*	90% (after Deductible)	70% Allowed Amount (after Deductible)

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

PLAN 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Skilled Nursing Facility/Extended Care Facility *(Precertification required; see* Medical Benefits *section for other limitations*) Up to 120* days per person, per Calendar Year, combined with Rehabilitation Hospital	90% (after Deductible)	70% Allowed Amount (after Deductible)
Speech Therapy (For treatment due to Illness or Injury; *see* Medical Benefits *section for other limitation*)	90% (after Deductible)	70% Allowed Amount (after Deductible)
Telemedicine (Applies to medical and behavioral health services; includes Doctor on Demand; *see* Medical Benefits *section for additional information*) All other virtual visits with a Provider with whom a Covered Person has established relationship, including, but not limited to Occupational Therapy, Physical Therapy and Speech Therapy	90% (after Deductible) Paid based on services provided	70% Allowed Amount (after Deductible) Paid based on services provided
Voluntary Termination of Pregnancy (Covered only in circumstances in which the life of the mother would be put in grave peril by continuing the pregnancy to term)	90% (after Deductible)	70% Allowed Amount (after Deductible)

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

PLAN 6

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY SOUTHERN SCRIPTS	
Prescription Drug Expense & Mail Order Option Note: Prescription drug Co-payments and Coinsurance accumulate toward the prescription drug Out-of-Pocket Maximums. Once the prescription drug Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% for the balance of the Calendar Year. Tobacco cessations products are covered at 100% Substitution of a generic equivalent medication is required; if a Covered Person requests the brand name medication be filled, the Covered Person pays the difference between the brand and generic drug, in addition to the brand name Co-payment, when a generic drug is available. Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Manager.	**Retail Card Program – You Pay:** (Up to a 30 day supply) $15 Co-payment per generic drug; $30 Co-payment per preferred brand name drug; $50 Co-payment per non-preferred brand name drug **Specialty Drug – You Pay:** (Up to a 30 day supply) 10% Coinsurance up to a maximum of $150 per generic drug; 20% Coinsurance up to a maximum of $150 per preferred brand name drug; 20% Coinsurance up to a maximum $250 per non-preferred brand name drug. **Mail Order Pharmacy – You Pay:** (Up to a 90 day supply) $35 Co-payment per generic drug; $75 Co-payment per preferred brand name drug; $125 Co-payment per non-preferred brand name drug Preventive drugs are covered with no cost sharing. Contraceptive medications are not covered.
Retail Card/Mail Order Pharmacy Calendar Year Out-of-Pocket Maximums: (Includes all applicable prescription drug Co-payments and Coinsurance)	$1,850 per person, up to $3,700 per family
Out-of-Network Pharmacy Coverage	NOT COVERED

PLAN 6

MEDICAL BENEFITS		
BENEFIT LEVELS	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Medical Calendar Year Deductible	Single Plan (Employee only): $2,500 Family Plan (Employee & family): $2,500 per person, up to $5,000 per family	Single Plan (Employee only): $2,500 Family Plan (Employee & family): $2,500 per person, up to $5,000 per family
Note: The Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the individual Deductible, claims will be paid for that individual. Otherwise, the entire family Deductible must be satisfied before claims will be paid for any family members. The family Deductible may be met by any combination of family members.		
Reimbursement Percentage ("Coinsurance")	80% of the Contracted Rate (after Deductible; unless otherwise stated)	60% of the Allowed Amount (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximums has been reached, then 100% thereafter for the balance of the Calendar Year
Medical Calendar Year Out-of-Pocket Maximums (Including all applicable Calendar Year Deductible and Coinsurance)	Single Plan (Employee only): $5,000 Family Plan (Employee & family): $5,000 per person, up to $10,000 per family	Single Plan (Employee only): $10,000 Family Plan (Employee & family): $10,000 per person, up to $20,000 per family
Note: The Family Plan contains both an individual Out-of-Pocket Maximums and a family Out-of-Pocket Maximums. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximums is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximums may be met by any combination of family members.		
The In-Network Provider and Out-of-Network Deductible and Out-of-Pocket Maximums are separate and do not accumulate. Eligible expenses which track toward the In-Network Provider Deductible and Out-of-Pocket Maximums will not be credited toward the satisfaction of the Out-of-Network Deductible and Out-of-Pocket Maximums and vice versa. **The following expenses are excluded from the Out-of-Pocket Maximum(s):** • Precertification penalties ***The Covered Person is also responsible to pay any amount above the Allowed Amount when services are rendered by an Out-of-Network Provider.***		

PLAN 6

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.		
****Routine Physical Exams** (Including routine and travel immunizations and flu shots)	100% (Deductible waived)	60% Allowed Amount (after Deductible)
****Routine Well Child Care** (Including screenings, routine and travel immunizations and flu shots)	100% (Deductible waived)	60% Allowed Amount (after Deductible)
****Fluoride Varnish** (Up to age 6) Up to four (4)* varnish treatments per person, per Calendar Year	100% (Deductible waived)	60% Allowed Amount (after Deductible)
****Breastfeeding Support, Supplies and Counseling** (During pregnancy and/or in the postpartum period and rental or purchase of breastfeeding equipment) <u>Breast Pump Limits</u>: • Hospital Grade Breast Pumps: rental covered up to 3 months; *precertification required* for rental in excess of 3 months • Electric Breast Pumps: rent or purchase, whichever is less; • Manual Breast Pumps: purchase	100% (Deductible waived)	60% Allowed Amount (after Deductible)
****Routine Gynecological/ Obstetrical Care** (Including preconception and prenatal services)	100% (Deductible waived)	60% Allowed Amount (after Deductible)
****Routine Pap Smears**	100% (Deductible waived)	60% Allowed Amount (after Deductible)
**** Breast Cancer Screening including Routine Mammograms and BRCA testing**	100% (Deductible waived)	60% Allowed Amount (after Deductible)
****Routine Immunizations** (If not billed with an office visit; includes flu shots and travel immunizations)	100% (Deductible waived)	60% Allowed Amount (after Deductible)
****Routine Lab, X-rays, and Clinical Tests** (Including those related to maternity care)	100% (Deductible waived)	60% Allowed Amount (after Deductible)

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

PLAN 6

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.		
****Routine Lab, X-rays, and Clinical Tests** (Including those related to maternity care)	100% (Deductible waived)	60% Allowed Amount (after Deductible)
****Routine Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies** (Age 50 and older)	100% (Deductible waived)	60% Allowed Amount (after Deductible)
****Lung Cancer Screening, including Low-Dose Computed Tomography (LDCT)** (Age 55 and older) Up to one (1)* per person, per Calendar Year	100% (Deductible waived)	60% Allowed Amount (after Deductible)
****Nutritional Counseling**	100% (Deductible waived)	60% Allowed Amount (after Deductible)
****Smoking Cessation Counseling and Intervention** (Including smoking cessation clinics and programs)	100% (Deductible waived)	60% Allowed Amount (after Deductible)
Routine Prostate Exams and Prostate-Specific Antigen (PSA) Screenings	100%	60% Allowed Amount (after Deductible)
****Abdominal Aortic Aneurysm Screening** (For men age 65 and over) Up to one (1)* per person, per lifetime	100% (Deductible waived)	60% Allowed Amount (after Deductible)
****Bone Density Screening** • Women age 60 and older • All other Covered Persons	 100% (Deductible waived) 100% (Deductible waived)	 60% Allowed Amount (after Deductible) 60% Allowed Amount (after Deductible)

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

PLAN 6

VISION CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Eyewear for Special Conditions (Includes lenses necessary to treat certain medical conditions; *see* Medical Benefits *section for other limitations*)	80% (after Deductible)	60% Allowed Amount (after Deductible)
PHYSICIAN SERVICES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Allergy Testing	80% (after Deductible)	60% Allowed Amount (after Deductible)
Allergy Treatment	80% (after Deductible)	60% Allowed Amount (after Deductible)
Anesthesia (Inpatient/Outpatient)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Chiropractic Services *(Precertification required after the first five (5)* visits)* Up to 12* visits per person, per Calendar Year	80% (after Deductible)	60% Allowed Amount (after Deductible)
Maternity (Employee & Spouse Only) (Includes Physician delivery charges, prenatal and postpartum care)		
• Prenatal care	100% (Deductible waived)	60% Allowed Amount (after Deductible)
• Physician delivery charges	80% (after Deductible)	60% Allowed Amount (after Deductible)
• Postnatal care	80% (after Deductible)	60% Allowed Amount (after Deductible)
Physician Hospital Visits	80% (after Deductible)	60% Allowed Amount (after Deductible)
Physician Office (Includes related charges billed at time of visit)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Second Surgical Opinion	80% (after Deductible)	60% Allowed Amount (after Deductible)
Surgery (Inpatient)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Surgery (Outpatient)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Surgery (Physician's office)	80% (after Deductible)	60% Allowed Amount (after Deductible)

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

PLAN 6

HOSPITAL SERVICES – INPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
Hospital Room & Board *(Precertification required)* Semi-private room or special care unit	80% (after Deductible)	60% Allowed Amount (after Deductible)
Maternity Services (Employee & Spouse Only) *(Precertification required for stays in excess of 48 hours[vaginal]; 96 hours [cesarean])* Semi-private room or special care unit	80% (after Deductible)	60% Allowed Amount (after Deductible)
Birthing Center (Employee & Spouse Only)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Newborn Care (Includes Physician visits & circumcision) Semi-private room or special care unit	80% (after Deductible)	60% Allowed Amount (after Deductible)
Organ, Bone Marrow and Stem Cell Transplants *(Precertification required; see* Medical Benefits *section for other limitations*) Semi-private room or special care unit Transportation/food/lodging limits: Lodging: $50 per night per person to a maximum of $100 per night; Overall Maximum is $10,000* per Transplant.	Managed through Cigna's LifeSOURCE Transplant Network®	80% Allowed Amount (after Deductible)
Surgical Facility & Supplies	80% (after Deductible)	60% Allowed Amount (after Deductible)
Miscellaneous Hospital Charges	80% (after Deductible)	60% Allowed Amount (after Deductible)

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

PLAN 6

HOSPITAL SERVICES – OUTPATIENT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
***Precertification for certain outpatient surgical procedures is required*. Failure to obtain precertification for certain outpatient surgical procedures may result in a reduction in benefits.**		
Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.		
Clinic Services (At a Hospital)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Emergency Room Expenses (Includes Facility, Lab, X-ray & Physician services) Non-Emergency Use	80% (after Deductible) 80% (after Deductible)	80% Allowed Amount (after In-Network Deductible) 60% Allowed Amount (after Deductible)
Outpatient Department	80% (after Deductible)	60% Allowed Amount (after Deductible)
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc. *(Precertification required for spinal procedures, and potentially cosmetic procedures)*	80% (after Deductible)	60% Allowed Amount (after Deductible)
Preadmission Testing	80% (after Deductible)	60% Allowed Amount (after Deductible)
Urgent Care Facility/Walk-In Clinic	80% (after Deductible)	60% Allowed Amount (after Deductible)
MENTAL HEALTH/ SUBSTANCE ABUSE	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
***Precertification is always required for inpatient hospitalization.* Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**		
Inpatient Hospitalization *(Precertification required)*	80% (after Deductible)	60% Allowed Amount (after Deductible)
Partial Hospitalization/Intensive Outpatient Treatment	100% (Deductible waived)	60% Allowed Amount (after Deductible)
Inpatient Physician Visit	80% (after Deductible)	60% Allowed Amount (after Deductible)
Hospital Clinic Visit	80% (after Deductible)	60% Allowed Amount (after Deductible)
Office Visit	80% (after Deductible)	60% Allowed Amount (after Deductible)

PLAN 6

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Ambulance Services (*See* Medical Benefits *section for limitations*)	80% (after Deductible)	80% Allowed Amount (after Deductible)
Autism Spectrum Disorders Treatment (Includes Applied Behavioral Analysis (ABA); benefit limits do not apply to occupational, physical and speech therapies; *precertification is required* for ABA; s*ee* Medical Benefits *section for limitations*) Note: Screenings are covered under Preventive Care	Benefits are based on services provided	Benefits are based on services provided
Bariatric Surgery (When related to treatment of Morbid Obesity; *see* Medical Benefits *section for other limitations)* Loop gastric bypass, Gastroplasty and Mini gastric bypass are not covered	80% (after Deductible)	60% Allowed Amount (after Deductible)
Cardiac Rehabilitation (Phase 1 and 2 only; *see* Medical Benefits *section for other limitations*)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Chemotherapy & Radiation Therapy *(Precertification required for Therapeutic Radiology for brachytherapy, proton beam therapy, radiotherapy)*	80% (after Deductible)	60% Allowed Amount (after Deductible)
Clinical Trials – Routine Services during Approved Clinical Trials (Limited to routine Covered Services under the Plan, including Hospital visits, laboratory, and imaging services; *see* Medical *Benefits section for other limitations*)	Benefits are based on services provided	Benefits are based on services provided
Dental/Oral Services (Includes excision of impacted wisdom teeth; *see* Medical Benefits *section for other limitations*)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Diabetes Self-Management Training and Education	80% (after Deductible)	60% Allowed Amount (after Deductible)
Diagnostic Imaging (MRI, CT Scan, PET Scan; *precertification required*)	80% (after Deductible)	60% Allowed Amount (after Deductible)

PLAN 6

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Diagnostic X-ray (Outpatient) **Diagnostic Laboratory (Outpatient)**	80% (after Deductible) 100% (Deductible waived)	60% Allowed Amount (after Deductible) 60% Allowed Amount (after Deductible)
Dialysis/Hemodialysis *(See* Medical Benefits *section for other limitations)*	80% (after Deductible)	60% Allowed Amount (after Deductible)
Durable Medical Equipment *(Precertification required for seat lifts, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators including TENS; see* Medical Benefits *section for other limitations)*	80% (after Deductible)	60% Allowed Amount (after Deductible)
Growth Hormones *(See* Medical Benefits *section for other limitations)*	80% (after Deductible)	60% (after Deductible)
Home Health Care *(Precertification required for home health care administered by a registered nurse, licensed practical nurse or for aid in the home or home infusion; see* Medical Benefits *section for other limitations; See* Medical Benefits *section for other limitations)* Up to 100* visits per person, per Calendar Year	80% (after Deductible)	60% (after Deductible)
Hospice Care (Inpatient/Outpatient) *(Precertification required for inpatient services; see* Medical Benefits *section for other limitations)* Up to 180* days per person, per Calendar Year	80% (after Deductible)	60% Allowed Amount (after Deductible)
Injectables *(Precertification required for immune globulin, drugs for factor deficiencies, interferon, Rituxan, some chemotherapeutic agents, botox)*	80% (after Deductible)	60% Allowed Amount (after Deductible)
Medical and Enteral Formula (Including metabolic formula; *precertification required; see* Medical Benefits *section for other limitations)*	80% (after Deductible)	60% Allowed Amount (after Deductible)

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

PLAN 6

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Neuromuscular Stimulator Equipment including TENS *(Precertification required)*	80% (after Deductible)	60% Allowed Amount (after Deductible)
Occupational Therapy (For treatment due to Illness or Injury; *precertification required after the first five (5)* visits; see* Medical Benefits *section for other limitation*)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Oral Pharynx Procedures (*Precertification required for uvulectomy, LAUP procedures, palatopharyngoplasty (PPP), uvulopalatopharyngoplasty (UPP)*; s*ee* Medical Benefits *section for other limitations*)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Orthotics (Excludes foot orthotics; s*ee* Medical Benefits *section for other limitations*)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Pain Management (Inpatient/Outpatient) (Includes payment for Pain Clinic and Pain Management Program fees)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Physical Therapy (For treatment due to Illness or Injury; *precertification required after the first five (5)* visits; see* Medical Benefits *section for other limitation*)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Podiatry Care *(See* Medical Benefits *section for limitations*)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Prosthetics *(Precertification required for extremity prosthetic additions; see* Medical Benefits *section for limitations*)	80% (after Deductible)	60% Allowed Amount (after Deductible)
Rehabilitation Hospital *(Precertification required*; s*ee* Medical Benefits *section for other limitations*) Up to 120* days per person, per Calendar Year, combined with Skilled Nursing Facility	80% (after Deductible)	60% Allowed Amount (after Deductible)
Respiratory Therapy	80% (after Deductible)	60% Allowed Amount (after Deductible)

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

PLAN 6

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Sleep Management Program *(Precertification required for obstructive sleep apnea, diagnostic or therapeutic sleep studies)*	80% (after Deductible)	60% Allowed Amount (after Deductible)
Skilled Nursing Facility/Extended Care Facility *(Precertification required; see* Medical Benefits *section for other limitations*) Up to 120* days per person, per Calendar Year, combined with Rehabilitation Hospital	80% (after Deductible)	60% Allowed Amount (after Deductible)
Speech Therapy (For treatment due to Illness or Injury; s*ee* Medical Benefits *section for other limitations)*	80% (after Deductible)	60% Allowed Amount (after Deductible)
Telemedicine (Applies to medical and behavioral health services; includes Doctor on Demand; *see* Medical Benefits *section for additional information*) All other virtual visits with a Provider with whom a Covered Person has established relationship, including, but not limited to Occupational Therapy, Physical Therapy and Speech Therapy	80% (after Deductible) Paid based on services provided	60% Allowed Amount (after Deductible) Paid based on services provided
Voluntary Termination of Pregnancy (Covered only in circumstances in which the life of the mother would be put in grave peril by continuing the pregnancy to term)	80% (after Deductible)	60% Allowed Amount (after Deductible)

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

V. MEDICAL BENEFITS

A. Benefit Levels

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

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

Out-of-Network Providers will be paid at In-Network Provider levels subject to the Allowed Amount, when covered ancillary medical services are rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility. In addition, Out-of-Network Providers will be paid at In-Network Provider Deductible, Co-payment and Coinsurance levels in the case of "Emergency Care" as defined in the section titled "Definitions". Covered ancillary medical services include the following types of professional services: anesthesia, radiology and pathology, as well as Covered Services provided by non-admitting consulting Physicians.

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

Deductible – For Plan 1, there is no Deductible that applies to Covered Services provided by In-Network Providers. For Plans 2 and 6, with respect to a Covered Person, the Deductible for Covered Services rendered by an In-Network Provider or an Out-of-Network Provider in each Calendar Year shall be as shown in the Schedule of Medical Benefits. The Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the individual Deductible, claims will be paid for that individual. Otherwise, the entire family Deductible must be satisfied before claims will be paid for any family members. The family Deductible may be met by any combination of family members.

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

For Plans 2 and 6, the In-Network and Out-of-Network Deductibles are separate and do not co-accumulate. Eligible In-Network expenses which track toward the In-Network Deductible will not be credited toward satisfaction of the Out-of-Network Deductible and vice versa.

Out-of-Pocket Maximum – The Out-of-Pocket Maximums are shown in the Schedule of Medical Benefits. The Family Plan contains both an individual Out-of-Pocket Maximum and a family Out-of-Pocket Maximum. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximum is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximum may be met by any combination of family members. For Plan 1, the Medical Out-of-Pocket Maximum excludes charges in excess of the Allowed Amount, Prescription Drug Co-payments, Coinsurance or Deductibles and any penalties for failure to follow Preadmission/ Precertification Requirements. For Plans 2 and 6, the Out-of-Pocket Maximum excludes charges in excess of the Allowed Amount, and any penalties for failure to follow Preadmission/ Precertification Requirements.

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

B. Complex Case Management/Alternate Treatment Coverage

If a Covered Person's condition is, or is expected to become, serious and complex in nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified organization. The purpose of the case management service is to help plan necessary, quality care in the most cost-effective manner with the approval and cooperation of the Covered Person, family and attending Physician(s). This is a voluntary service to help manage both care and cost of a potentially high-risk or long term medical condition, and neither Covered Persons nor treating Physicians are required to participate in complex case management.
If a case is identified as appropriate for complex case management, then the case management organization will contact the treating Physician(s) and Covered Person to develop and implement a mutually agreeable treatment plan. If either the attending Physician or the Covered Person does not wish to follow the treatment plan, benefits will continue to be paid as stated in the Plan.

If the Physician(s) and Covered Person agree to the treatment plan, in some cases services not normally covered by the Plan may be eligible for coverage. If it appears that the most appropriate and cost-effective care will be rendered in a setting or manner not usually covered under the terms of the Plan, such care may be covered under the auspices of a complex case management treatment plan. In such cases, all Medically Necessary services included in the approved treatment plan will be covered under the terms of the Plan. However, the coverage of services under a complex case management plan that are

not otherwise covered under this Plan does not set any precedent or create any future liability for coverage of such services with respect to either the Covered Person who is the subject of the plan or any other Covered Persons. Benefits provided under this section are subject to all other Plan provisions.

C. Covered Services

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

(1) Prescription Drugs

Expenses for covered prescription drugs and medicines will be covered as described in the section titled "Schedule of Medical Benefits" through retail pharmacies and the Prescription Benefit Manager's mail order program.

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

Variable Copay Program

The Plan has adopted the Southern Scripts Variable Copay™ Program to help Covered Persons who utilize manufacturer Co-payment programs save money on prescription drugs. Under the Variable Copay™ Program, the out-of-pocket cost for prescription drugs may be reduced or eliminated by a drug manufacturer's Co-payment subsidy. **Note: Any manufacturer copay subsidy obtained under the Variable Copay™ Program will not accumulate toward your deductible or out of pocket costs.** If a Covered Person is eligible to receive a manufacturer Co-payment subsidy for a drug, his or her Co-payment obligation for that drug will be the maximum manufacturer Co-payment subsidy for that drug. If a Covered Person is not eligible to receive a manufacturer Co-payment subsidy, his or her Co-payment obligation will be the Co-payment amount listed for the drug in the standard formulary under the Plan. **Note: if a Covered Person is eligible for a manufacturer Co-payment subsidy for a drug but fails to obtain the subsidy, his or her Co-payment obligation – and the out-of-pocket cost he or she may be required to pay – will be the maximum manufacturer Co-payment**

subsidy for that drug. A detailed schedule of subsidies available through manufacturer Co-payment programs under the Variable Copay™ Program at http://crxspecialty.com or may be accessed free of charge by contacting (800) 710-9341.

For more information regarding prescription drug coverage under this Plan, go to www.healthplansinc.com or call Southern Scripts at the telephone number on your ID card.

Manufacturer Free Drug Initiative

The Plan offers voluntary enrollment in the Manufacturer Free Drug Initiative to help Covered Persons save money on prescription drugs. If a Covered Person chooses to enroll and receive a drug at no cost through a manufacturer free drug program, that drug will not be covered under the Plan and the Covered Person will have no cost sharing obligation to the Plan for that drug.

Prescription drug charges not covered, including but not limited to:

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

(b) Administration of drugs;

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

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

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

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

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

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

(2) Preventive Care

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

(a) **Routine physicals

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

(b) **Routine Well Child Care

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

(c) **Women's Preventive Services

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

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

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

(d) **Routine gynecological/obstetrical care

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

(e) **Breast cancer screening

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

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

(g) **Routine colorectal cancer screening

Includes fecal occult screening, sigmoidoscopy and colonoscopy

(h) ** Lung cancer screening

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

(i) **Nutritional counseling

(j) **Smoking cessation counseling and intervention

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

(k) Routine prostate exam

Includes Prostate-Specific Antigen (PSA) screening

(l) **Abdominal aortic aneurysm screening

(m) **Bone density screening

(3) Vision Care

(a) Vision eyewear for special conditions:

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

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

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

(4) Physician Services

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

(b) Anesthesia (Inpatient/Outpatient)

(c) Chiropractic services from a licensed provider

(d) Maternity (Employee and Spouse Only)

Includes delivery, prenatal, and postpartum care of mother and fetus.

Amniocentesis is included for women age thirty-five (35) and older.

(e) Physician Hospital visits

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

(f) Physician office visits

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

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

Fees of a legally qualified Physician for a second surgical consultation when non-emergency or elective surgery is recommended by the Covered Person's attending Physician. The Physician rendering the second opinion regarding the Medical Necessity of such surgery must be qualified to render such a service, either through experience, specialization training, education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery; and

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

(h) Surgery (inpatient/outpatient/office)

Physician or surgeon charges for a surgical operation and for the administration of anesthesia
If two or more surgical procedures are performed at one time through the same incision in the same operative field, the maximum allowable amount for the surgery will be as follows:

(i) For In-Network Providers: the Contracted Rate for the primary procedure and the greater of 50% of the Contracted Rate or the

amount specified in the In-Network Provider's contract for the secondary or lesser procedure(s).

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

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

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

(5) Hospital Services – Inpatient

(a) Hospital room & board

Hospital room and board for a semiprivate room, intensive care unit, cardiac care unit or burn care unit, but excluding charges for a private room which are in excess of the Hospital's semiprivate room rate. Charges made by a Hospital for a private room when: i) determined to be Medically Necessary, ii) a semi-private room is not available; or iii) the Hospital only has private rooms will be allowed at the private room rate with no reduction. If a semi-private room is available and the Covered Person chooses a private room, charges for a private room which are in excess of the Hospital's semi-private room rate will be excluded or, if the semi-private rate is not available, reduced by 20%

(b) Maternity services (Employee and Spouse Only)

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

Note: If the mother chooses to be discharged earlier, coverage is provided for one (1) home visit by a Physician, Registered Nurse, nurse midwife or nurse practitioner within 48 hours of discharge. This visit may include: parent education, assistance and training in breast or bottle feeding, and appropriate tests.

No authorization from the Plan need be sought by the attending Physician for prescribing a length of inpatient stay for the mother or newborn not in excess of 48 hours (or 96 hours, for a cesarean section). The 48- or 96-

hour limit may be exceeded with precertification in cases of Medical Necessity by calling (800) 532-7575.

(c) Birthing Center (Employee and Spouse Only)

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

(d) Newborn care

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

(e) Mastectomy

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

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

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

(iii) Prostheses; and

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

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

(f) Organ transplants

Organ transplants for organ and bone marrow/stem cell transplantation are managed through the CIGNA LifeSource Transplant Network®. The Cigna LifeSOURCE Transplant Network® is a transplant network that is made up of more than 160 transplant facilities.

The Cigna LifeSOURCE Program of Excellence consists of in-network facilities that have met quality standards and have contracted with Cigna LifeSOURCE to provide transplant services as a participating provider in the Cigna LifeSOURCE Transplant Network®. The program includes a team of nurse transplant case managers that serve as the Covered Person's one point of contact within Cigna. A list of in-network facilities and the transplant programs for which they are contracted can be accessed at https://cignalifesource.com/assets/docs/cignalifesource/cigna-lifesource-programs-of-excellence.pdf.

If a facility is not included in the CIGNA LifeSource Transplant Network®, transplant services may be covered at the out-of-network level of benefits as outline in the Schedule of Medical Benefits.

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

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

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

(ii) Organ transplantation;

(iii) Organ procurement as follows:

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

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

If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to

the time of reinfusion. The harvesting of the marrow need not be performed within the Transplant Benefit Period.

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

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

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

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

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

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

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

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

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

(6) Surgical Facility and Supplies

(7) Miscellaneous Hospital Charges

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

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

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

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

(8) Hospital Services – Outpatient

(a) Clinic services

(b) Emergency room services

(c) Outpatient department

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

(e) Preadmission testing

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

(f) Urgent care facility/walk-in clinic

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

(9) Mental Health/Substance Use Disorders

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

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

(a) Comprehensive health service organization;

(b) Licensed or accredited Hospital;

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

(d) Licensed detoxification facility;

(e) Licensed social worker;

(f) Psychologist; or

(g) Psychiatrist

(10) Other Services and Supplies

(a) Ambulance services:

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

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

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

(b) Autism Spectrum Disorders treatment

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

(c) Bariatric surgery for the treatment of Morbid Obesity

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

(e) Cardiac rehabilitation

Expenses for Cardiac Rehabilitation Program (limited to Phase I and Phase II only) provided such treatment is recommended by the attending Physician. Phase I consists of acute inpatient hospitalization, whether for heart attack or heart surgery, highly supervised with a tailored exercise program with continuous monitoring during exercise. Phase II consists of supervised outpatient treatment for Covered Persons who have left the Hospital but still need a certain degree of supervised physical therapy and

monitoring during exercise. Phase II services are usually tailored to meet the Covered Person's individual need. Benefits are not payable for Phase III which consists of outpatient services without supervision. The Phase III program is developed for patients who are well enough to continue exercising on their own, monitoring their own progress.

(f) Chelation therapy

(g) Chemotherapy and radiation therapy

(h) Chiropractic services

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

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

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

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

(iii) These services are Covered Services under the Plan

(j) Dental/oral services (limited)

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

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

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

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

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

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

(k) Diabetes self-management training and education

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

(m) Diagnostic x-ray and laboratory

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

(n) Dialysis/Hemodialysis

Hemodialysis (renal therapy) at a Medicare-approved dialysis center

(o) Durable medical equipment

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

(p) Growth hormones

Growth hormones when prescribed by a board certified pediatric endocrinologist. The Covered Person must be seen by the attending Physician every six (6) months and a written response to the treatment must be verified by the Physician. The medication will be covered for a thirty (30) day supply at a time.

(q) Home health care

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

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

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

(iii) Services provided by home health aides;

(iv) Services of a medical social worker; and

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

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

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

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

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

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

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

(v) Home health aide service;

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

Registered Nurse, a Licensed Practical Nurse, or a home health aide;

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

(viii) Nutrition services provided by a licensed dietitian;

(ix) Respite care for Covered Persons who are members of the hospice patient's immediate family (for the purposes of hospice benefits, the term immediate family means – parents, Spouse and children); and

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

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

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

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

(t) Medical and enteral formulas

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

(u) Miscellaneous medical supplies (outpatient)

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

(v) Occupational therapy

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

(w) Orthoptics

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

(x) Orthotics (excluding foot orthotics)

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

(y) Oxygen and other gasses and their administration

(z) Pain management programs/clinics

(aa) Physical therapy

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

(bb) Podiatry care

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

(cc) Prosthetics

Prosthetic appliances such as artificial arms and legs including accessories; larynx prosthesis; eye prosthesis; breast prosthesis (made necessary due to breast removal arising from Illness or Injury), and surgical brassieres when purchased following a mastectomy. Excludes replacement, repair or adjustment, unless the replacement, repair or

adjustment is necessary because of physiological changes or the prosthesis that is being replaced is at least five (5) years old and no longer serviceable.

(dd) Rehabilitation Hospital

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

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

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

(ee) Respiratory therapy

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

(ff) Skilled Nursing Facility

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

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

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

(gg) Sleep disorders

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

(hh) Speech therapy

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

(ii) Telemedicine services

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

(i) Telemedicine/telehealth visits

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

(ii) e-Visits/virtual visits

Non-face-to-face patient-initiated communications with a Covered Person's doctor(s) without going to the doctor's office by using online patient portals. E-visits/virtual visits are covered when the Provider has an established relationship with the Covered Person

(jj) Termination of pregnancy

Covered only in circumstances in which the life of the mother would be put in grave peril by continuing the pregnancy to term

VI. MEDICAL LIMITATIONS AND EXCLUSIONS

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

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

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

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

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

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

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

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

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

(9) Expenses incurred outside the United States if the Covered Person traveled to such location for the primary purpose of obtaining medical services, drugs or supplies, except for benefits specifically stated as covered under the Plan

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

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

(12) Expenses incurred in connection with an Injury arising out of, or in the course of, any employment for wage or profit, or disease covered with respect to such employment, by any Worker's Compensation Law, Occupational Disease Law or

similar legislation, with the exception of when a Covered Person is not covered by Worker's Compensation Law and lawfully chose not to be

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

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

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

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

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

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

(19) Expenses incurred in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the Covered Person actually had such mandatory coverage. Any claims which arise in connection with an automobile accident for which the policy provides an option for medical coverage are excluded. Benefits will be excluded to the maximum amount of first party medical coverage available under the applicable state law, regardless of a Covered Person's election of lesser coverage. This exclusion does not apply if the injured Covered Person is a passenger in a non-family owned vehicle or a pedestrian.

(20) Acupuncture therapy

(21) Biofeedback

(22) Childbirth classes

(23) Cochlear implants

(24) Contraceptive services, including without limitation, coverage for any of the following: contraceptive methods and counseling; FDA approved contraceptive methods; and sterilization procedures and patient education and counsel for women with reproductive capacity

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

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

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

(28) Early Intervention services

(29) Erectile dysfunction treatment

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

(31) Family planning services

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

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

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

(35) Genetic counseling, testing, or related services, except for benefits specifically stated as covered

(36) Growth hormones

(37) Health/fitness club reimbursement

(38) Hearing aids or similar devices, and the fitting of hearing aids

(39) Hearing exam for routine care

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

(41) Infertility treatment including medicines, and surgical procedures

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

(43) Marital counseling

(44) Massage therapy

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

(46) Methadone maintenance and treatment

(47) Modified low protein foods

(48) Naturopathic medicine

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

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

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

(52) Planned home births

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

(54) Private duty nursing

(55) Reverse sterilization

(56) Sex therapy

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

(58) Vision exams for routine care

(59) Visual refraction surgery, including radial keratotomy

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

(61) Voluntary sterilization

(62) Weight loss programs

(63) Wigs

VII. ELIGIBILITY, ENROLLMENT AND PARTICIPATION

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

A. Eligibility

The following religious organizations will determine which classes of Employees and clergy of participating Employers within the Archeparchy, Eparchy or Diocese will be eligible to participate in the Plan:

- Metropolitan Archeparchy of Pittsburgh
- Byzantine Catholic Eparchy of Parma
- Byzantine Catholic Eparchy of Passaic
- Diocese of Newton for the Melkites
- Eparchy of Our Lady of Lebanon of Los Angeles

Any Employee who is eligible for another plan sponsored by a Participating Employer and/or Plan Sponsor is not eligible for participation in this Plan.

Employees should contact their respective religious organization regarding their eligibility to receive coverage under the Plan.

B. Enrollment

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

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

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

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

Enrollment/Election Periods

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

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

(1) Initial Eligibility Period

An Employee may elect to enroll in this Plan during the 31-day period following the date of hire by submitting all required forms to the Plan Administrator. Any election made to enroll or not to enroll during the initial eligibility period will be irrevocable for the duration of the Plan Year unless the Employee becomes eligible to change an election during an enrollment period described below.

(2) Open Enrollment Period

During open enrollment periods held on dates determined by the Plan Administrator, an Employee may change elections with respect to enrollment in this Plan for the Employee, and/or Eligible Dependents.

(3) Qualified Change in Status

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

- Marriage, legal separation, annulment or divorce of the Employee;
- Birth, adoption or placement for adoption, or change in custody of the Employee's child;

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

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

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

(4) Special Medicaid/CHIP Enrollment Period

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

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

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

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

(a) Enrollment following involuntary loss of other coverage

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

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

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

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

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

- All benefits under the alternative coverage have been exhausted under its lifetime benefit limits; or

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

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

(b) Enrollment following acquisition of Eligible Dependents

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

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

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

C. Participation

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

When Participation Begins/Ends

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

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

Newborn Children

Coverage for a newborn child of a Covered Employee is provided for the first 31 days of life regardless of whether the newborn is enrolled in the Plan. No coverage is provided after the 31-day period, unless the newborn child is enrolled in this Plan within the applicable enrollment/election deadlines, as outlined above and in the Enrollment/Elections Periods table in Section B. *Enrollment*.

(1) Participation during Periods of Leave of Absence

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

(a) Leave of Absence under FMLA

A covered Employee who is entitled to and takes a family or medical leave under the terms of the FMLA (Family and Medical Leave Act of

1993, as amended), and any covered dependents, may continue to participate in this Plan until the earliest of:

(ii) The expiration of the leave, or

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

(b) Leave of Absence for Military Service

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

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

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

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

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

Employees who enter into special written agreements with the Employer are eligible to continue participation in the Plan following termination of employment as specified under the terms of each individual's agreement.

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

(a) Return from FMLA Leave

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

return in accordance with the provisions of Section A of this Article, Eligibility.

(b) Return from Military Service Leave

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

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

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

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

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

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

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

(d) Reemployment in General

Participation in the Plan will be in accordance with the provisions set forth by each of the participating religious organizations for any former enrolled Employee and their Eligible Spouse and Dependents if the Employee is rehired within the period established by the Employer. In the case of an Employee rehired who had not satisfied the Waiting Period as of the termination date, the Waiting Period will be reduced by the period of prior employment.

In each other case of reemployment beyond the period established by the Employer or return to eligible status from ineligible status, the Covered Person will become covered upon the Employee's return to Actively at Work full-time status in accordance with the provisions set forth by each of the participating religious organizations

VIII. COORDINATION OF BENEFITS

A. Maximum Benefits Under All Plans

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

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

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

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

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

B. Other Plan

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

(1) Any primary payer besides this Plan;

(2) Any other group health plan;

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

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

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

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

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

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

C. Excess Insurance

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

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

(1) Any primary payer besides this Plan;

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

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

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

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

D. Vehicle Limitation

When medical payments are available under any vehicle insurance, this Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the Exclusions and Limitations provisions set forth in this Plan up to the maximum amount available to the Covered Person under applicable state law, regardless of a Covered Person's election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles or classifications.

E. Determining Order of Payment

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

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

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

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

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

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

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

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

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

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

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

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

F. Facilitation of Coordination

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

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

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

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

G. Persons Covered by Medicare

In accordance with federal law, the following rules apply in determining whether Medicare or Plan coverage is primary health care coverage:

(1) **The Working Aged Rule**: Medicare benefits are secondary to benefits payable under the Plan for individuals entitled to Medicare due to being age 65 or over and who have Plan coverage as a result of his or her current employment status (or the current employment status of a Spouse) if they are employed by an employer with 20 or more employees. In all other cases, benefits under the Plan are secondary to Medicare benefits. When you or your Spouse become eligible for Medicare due to the attainment of age 65, you or your Spouse may still be eligible for benefits provided under the Plan based on your current employment status. If, as a result, you have or your Spouse has primary coverage under the Plan, the Plan will pay the portion of your incurred expenses that are normally covered by the Plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have Plan coverage.

(2) **The Working Disabled Rule**: Medicare benefits are secondary to benefits payable under the Plan for covered individuals under age 65 entitled to Medicare on the basis of disability (other than end-stage renal disease) and who are covered under the Plan as a result of current employment status with an employer. That is, if you or your dependents are covered by the Plan based on your current employment status, Medicare benefits are secondary for you or your covered Dependents entitled to Medicare on the basis of disability (other than end-stage renal disease). In this case the Plan is primary.

(3) **End-Stage Renal Disease Rule**: Medicare benefits are secondary to benefits payable under the Plan for covered individuals eligible for or entitled to Medicare benefits on the basis of end-stage renal disease ("ESRD"), for a period not to exceed 30 months generally beginning the first day of the month of eligibility or entitlement to Medicare due to ESRD. (Special rules apply if you were entitled to Medicare based on age or disability prior to becoming eligible for Medicare due to ESRD.) Because an ESRD patient can have up to a three-month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to

three months. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. Your Employer can provide you with more detailed information on how this rule works.

H. Discrimination Against Older Participants Prohibited

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

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

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

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

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

K. Medicare and Medicaid Reimbursements

The Plan will reimburse the Centers for Medicare and Medicaid Services or any successor government agency for the cost of any items and services provided by Medicare for any Covered Person that should have been borne by this Plan. Similarly, this Plan will reimburse any state Medicaid program for the cost of items and services provided under the state plan that should have been paid for by this Plan.

L. Right to Receive and Release Necessary Information

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

insurance company or other organization or person any information, with respect to any person, which is deemed to be necessary for such purposes.

M. Facility of Payment

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

N. Right of Recovery

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

IX. PLAN ADMINISTRATION

A. Plan Administrator

The Plan Administrator will be appointed by the Employer.

B. Allocation of Authority

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

(1) To interpret the Plan, the Summary Plan Description, and any other writings affecting the establishment or operation of the Plan, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits, and to decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.

(2) To make factual findings and decide conclusively all questions regarding any claim for benefits under the Plan.

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

C. Powers and Duties of Plan Administrator

The Plan Administrator will have the following powers and duties:

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

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

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

(4) To determine the amount of benefits that will be payable to any person in accordance with the provisions of the Plan; to inform the Employer, as appropriate, of the amount of such Benefits; and to provide a full and fair review

to any covered individual whose claim for benefits has been denied in whole or in part

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

D. Delegation by the Plan Administrator

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

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

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

E. Indemnification and Exculpation

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

F. Compensation of Plan Administrator

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

G. Bonding

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

H. Payment of Administrative Expenses

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

X. TERMINATION AND CONTINUATION OF COVERAGE

A. Termination of Coverage

(1) Termination Events

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

(a) The last day of the month in which the Employee terminates employment

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

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

(d) The last day of the month in which the Employer terminates the Employee's coverage

(e) The day this Plan terminates

(f) The last day of the month in which the Employee dies

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

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

(2) Earlier Termination of Eligible Dependent Coverage

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

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

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

(c) The thirty-first (31st) day following birth for a newborn Eligible Dependent child if the Employee fails to enroll the newborn in coverage

within the applicable enrollment/election deadlines as described in the *Eligibility, Enrollment and Participation* section in this document

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

(3) Rescissions

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

XI. HIPAA PRIVACY AND SECURITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Archbishop
- Employees and other workforce members at the direction of the above listed classes of employees

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

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

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

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

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

XII. THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT PROVISIONS

A. Payment Condition

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

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

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

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

B. Subrogation

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

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

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

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

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

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

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

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

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

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

C. Right of Reimbursement

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

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

(3) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which

attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

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

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

D. Covered Person is a Trustee Over Plan Assets

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

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

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

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

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

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

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

E. Release of Liability

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

F. Excess Insurance

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

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

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

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

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

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

G. Separation of Funds

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

bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

H. Wrongful Death

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

I. Obligations

(1) It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

(a) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

(b) To provide the Plan with pertinent information regarding the Injury, Illness, disease, or disability, including accident reports, settlement information and any other requested additional information;

(c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

(d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

(e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;

(f) To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan;

(g) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage;

(h) To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;

(i) In circumstances where the Covered Person(s) is not represented by an attorney, instruct the insurance company or any third party from whom the

Covered Person(s) obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and

(j) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person(s) over settlement funds is resolved.

(2) If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury Illness, disease or disability, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

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

J. Offset

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

K. Minor Status

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

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

L. Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights

with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

M. Severability

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

N. Definitions

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

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

XIII. AMENDMENT AND TERMINATION OF PLAN

A. Amendment

The Employer has the right to amend this Plan in any and all respects at any time, and from time to time, without prior notice.

Any such amendment will be by a written instrument signed by a duly authorized Officer of the Employer.

The Plan Administrator will notify all Covered Persons of any amendment modifying the material terms of the Plan as soon as is administratively feasible after its adoption, but in no event later than 210 days after the close of the Plan Year in which the amendment has been adopted. Such notification will be in the form of a Summary of Material Modifications unless incorporated in an updated Summary Plan Description.

Notwithstanding the above, to the extent the material change is a material reduction in Covered Services or benefits such Summary of Material Modifications shall be distributed within 60 days of the date of adoption of such change.

B. Termination of Plan

Regardless of any other provision of this Plan, the Employer reserves the right to terminate this Plan at any time without prior notice. Such termination will be evidenced by a written resolution of the Employer. The Plan Administrator will provide notice of the Plan's termination as soon as is administratively feasible, but no more than 210 days after the last day of the final Plan Year.

C. Termination by Dissolution, Insolvency, Bankruptcy, Merger, etc.

This Plan will automatically terminate if the Employer (1) is legally dissolved; (2) makes any general assignment for the benefit of its creditors; (3) files for liquidation under the Bankruptcy Code; (4) merges or consolidates with any other entity and it is not the surviving entity; (5) sells or transfers substantially all of its assets; or (6) goes out of business, unless the Employer's successor in interest agrees to assume the liabilities under this Plan as to the Covered Persons.

XIV. GENERAL PROVISIONS

A. Company Funding

Some benefits may be provided through insurance contracts, either through the Trust or otherwise. To the extent that any benefits are not provided through the Trust or through insurance contracts outside the Trust, they are paid from your Employer's general assets. No Employees shall have any right, title, or interest whatever in or to any investment reserves, accounts, or funds that the Employer may purchase, establish, or accumulate to aid in providing benefits under this Plan. Nothing contained in this Plan, and no action taken under its provisions, shall create a trust or fiduciary relationship of any kind between the Employer and an Employee or any other person. Neither an Employee nor a beneficiary of an Employee shall acquire any interest greater than that of an unsecured creditor.

B. In General

Any and all rights provided to any person under this Plan shall be subject to the terms and conditions of the Plan. This Plan shall not constitute a contract between the Employer and any Covered Person, nor shall it be consideration or an inducement for the initial or continued employment of any Employee. Likewise, maintenance of this Plan shall not be construed to give any Employee the right to be retained as an Employee by the Employer or the right to any benefits not specifically provided by the Plan.

C. Waiver and Estoppel

No term, condition, or provision of this Plan shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Employee or eligible Beneficiary other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

D. Effect on Other Benefit Plans

Amounts credited or paid under this Plan shall not be considered to be compensation for the purposes of a qualified pension plan maintained by the Employer. The treatment of the amounts paid under this Plan under other Employee benefit plans shall be determined under the provisions of the applicable Employee benefit plan.

E. Nonvested Benefits

Nothing in this Plan shall be construed as creating any vested rights to benefits in favor of any Employee or Eligible Dependent.

F. Interests not Transferable

The interests of the Employee and their Eligible Dependents under this Plan are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, alienated, assigned or encumbered without the written consent of the Plan Administrator.

G. Severability

If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Employer shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

H. Headings

All Article and Section headings in this Plan have been inserted for convenience only and shall not determine the meaning of the content thereof.

I. Limitations on Actions

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal has been rendered (or deemed rendered).

XV. CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS

Claims and Appeals Procedures

This section describes a Covered Person's rights and obligations with respect to filing claims, receiving timely notice about whether and the extent to which benefits are payable, and the option to appeal a claim that has been denied in whole or in part.

Designating an Authorized Representative

For initial claims
For the purposes of filing initial claims for coverage under the Plan, the health care provider who rendered services to the Covered Person is deemed to be an authorized representative, and most claims are filed by health care providers directly with the Claim Administrator. The Covered Person may also designate another person to be the authorized representative for filing claims by completing the applicable section of the Member Reimbursement form. The Member Reimbursement form can be completed online at the Plan web site shown on the Plan ID card; downloaded and printed; or requested from the Claim Administrator. After an authorized representative has been designated, all subsequent notices and decisions concerning claims will be provided to the Covered Person through his or her authorized representative. Claims are subject to the filing limits described in this Article.

For appeals or requests for external review
For the purposes of filing appeals or requesting external review of denied Urgent Care Claims (defined below) on behalf of a Covered Person, the Covered Person's treating health care provider is deemed to be an authorized representative. The Covered Person may also name another individual as an authorized representative for appeals and external review by completing and submitting a Designation of Personal Representative Authorized for Claim Appeal and/or External Review Request form (DPR form), available upon request from the Claim Administrator. For a health care provider to appeal or request review of a non-Urgent Care Claim on behalf of the Covered Person, the Covered Person must execute a DPR form naming the provider as the authorized representative. After an authorized representative has been designated, all subsequent notices and decisions concerning appeals or requests for external review will be provided to the Covered Person through his or her authorized representative.

Exhaustion of Internal Appeals Required

Under this Plan, there are two levels of mandatory internal appeals. A Covered Person is required to exhaust both levels of the internal appeals process before requesting an external review or pursuing other legal remedies that may be available except in the following situations: 1. In cases involving Urgent Care Claims, the Covered Person may forego the internal appeals process and request an expedited external review upon receipt of the initial claim denial and 2. In cases where the Plan has not adhered to the claims and appeals requirements specified in this Plan and the violation is more than *de minimis*, the internal review process may be deemed to be

exhausted and the Covered Person may initiate an external review or take other available legal action. Appeals, requests for external review and other legal actions are subject to the filing periods described in this Article and the *General Provisions/Limitations on Actions* section of this Summary Plan Description.

Claims and Appeals Overview

The Plan Administrator has delegated the administration of claims processing under the Plan to the Claim Administrator. As directed by the Plan Administrator, the Claim Administrator, or for prescription claims the Prescription Benefit Manager, makes initial claim and initial appeal determinations based on the specific terms of the Plan. The Plan Administrator has authority to determine the amount of benefits that will be paid on any particular benefit claim, and has discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claims.

The steps involved in claims and appeals processing are outlined below. Important details about the required procedures and Covered Persons' rights are included in Sections A-F below.

(1) All initial claims must be filed within one (1) year of the Expense Incurred Date (as defined in the Article titled "Definitions" of this Summary Plan Description).

(2) As directed by the Plan Administrator, the Claim Administrator, or for prescription claims the Prescription Benefit Manager, will make an initial determination about benefits payable based on the specific terms of the Plan and will notify the Covered Person within the period specified for the type of claim filed (see *D. Initial Claim Determination*, and Chart A, below).

(3) If the claim is denied in whole or in part, it is called an adverse benefit determination. An adverse benefit determination includes a "rescission" (retroactive termination) of an individual's coverage under the Plan due to fraud or intentional misrepresentation. If the and the Covered Person disputes the determination, he or she may contact the Claim Administrator, or for prescription claims the Prescription Benefit Manager, to confirm that the claim was properly processed, or may file a formal internal appeal (see *F. Internal Appeals and External Review of Denied Claims,* below). Note that in cases of Urgent Care Claim denials based in whole or in part on medical judgment, the Covered Person may forgo the internal appeals process and request an expedited external review (*see 6 below*).

(4) As directed by the Plan Administrator, the Claim Administrator, or for prescription claims the Prescription Benefit Manager, will review the first internal appeal and will make an appeal determination based on the specific terms of the Plan within the period specified for the type of claim that is the subject of the appeal (see *F. Internal Appeals and External Review of Denied Claims*, Chart B below).

(5) If the first internal appeal is denied, the Covered Person may file a second internal appeal with the Claim Administrator, or for prescription claims the Prescription Benefit Manager, within the time periods specified in Chart B, below. In cases of Urgent Care Claim denials based in whole or in part on medical judgment, the Covered Person may forego the second internal appeal and request an expedited external review (*see 6 below*). The appeal will be reviewed by the Plan Administrator, who holds the authority to make the final determination about benefits payable under the Plan. The second appeal is the final internal appeal required (except as described under *Exhaustion of Internal Appeals Required* above) and available under the Plan.

(6) If the final internal appeal is denied in whole or in part and the denial is related to a rescission or is based on medical judgment, or if the initial denial was for an Urgent Care Claim, the Covered Person (or authorized representative) has the right to request an external review by an independent review organization (IRO) within the time periods specified in Chart B, below. The IRO will review the denial and issue a final decision within the period specified for the type of claim that is the subject of the review. The Covered Person may also elect to take legal action as may be available under state or federal law instead of or following external review, provided such action is initiated within the time period described under the *General Provisions/Limitations on Actions* section of this Summary Plan Description.

A. Who May File a Claim

A Covered Person's health care service provider may submit claims, and most claims are submitted by providers directly to the Claim Administrator. Alternatively, a claim may be filed by a Covered Person, or by his or her authorized representative. See *Designating an Authorized Representative*, above. After an authorized representative has been designated, all subsequent notices and decisions concerning claims will be provided to the Covered Person through his or her authorized representative.

B. Types of Claims

The time limits applicable to claims and appeals depend on the type of claim at issue. The categories of potential claims are defined below.

(1) Urgent Care Claim – a claim for medical care or treatment where using the time periods allowed or making non-Urgent Care Claim determinations (a) could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment being claimed

(2) Concurrent Care Claim – a claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim

(3) Pre-Service Claim – a claim for a benefit that requires approval (usually referred to as precertification or preauthorization) under the Plan in advance of obtaining medical care

(4) Post-Service Claim – a claim for services that have already been provided or that do not fall into any of the categories above

C. When and How to File a Claim

An initial claim for inpatient benefits must be submitted by the Covered Person, or by the Covered Person's health care provider or other authorized representative, no later than one (1) year after the discharge date or the date coverage under this Plan ends, whichever occurs first. For outpatient benefits, claims must be submitted no later than one (1) year after the date that services are provided. Claims received after that date will be denied. This time limit does not apply if the Covered Person is legally incapacitated.

How a claim may be filed depends on the type of claim:

(1) *Urgent Care Claims, including Urgent Concurrent Care Claims,* may be submitted verbally by calling the Claim Administrator at (800) 532-7575 or by any method available for Non-Urgent Care Claims and Post-Service Claims.

(2) *Non-Urgent Care, Pre-Service* and *Post-Service Claims* may be filed electronically or using a written form available from the Claim Administrator, and must be submitted to the Claim Administrator using one of the following methods:

- Electronically
- U.S. Mail
- Hand delivery
- Facsimile (FAX): (508) 329-4812

Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581	**Mailing Address:** Health Plans, Inc. P.O. Box 5199 Westborough, MA 01581

D. Initial Claim Determination

After a claim has been submitted to the Claim Administrator, the Plan will make a determination within specified time limits, depending on the type of claim. In some cases, the time limits may be extended if there are circumstances beyond the Claim Administrator's control that require a delay, or if the claim was submitted improperly or

lacked information necessary to make a determination. In such cases, the Covered Person will be notified about the need for a delay or for additional information regarding the claim within a specified period of time.

The following table shows the applicable time limits based on type and specific circumstances of the claim.

CHART A – Time Limits Regarding Initial Claims				
Type of Initial Claim	**Maximum period after receipt of claim for initial benefits determination**	**Maximum extension of initial benefits determination for delays beyond the control of Claim Administrator**	**Maximum period to notify Covered Person of improperly filed claim or missing information**	**Period for Covered Person to provide missing information**
URGENT CARE CLAIMS (not including Urgent Concurrent Care Claims)	72 hours	No extension permitted	24 hours	48 hours minimum*
URGENT CONCURRENT CARE CLAIMS**	24 hours	No extension permitted	24 hours	48 hours minimum*
NON-URGENT CONCURRENT CARE AND PRE-SERVICE CLAIMS	15 days	15 days	15 days	45 days maximum
POST-SERVICE CLAIMS	30 days	15 days	30 days	45 days maximum

*A determination will be made within 48 hours of receiving both a properly filed claim and any missing information.
**Provided the claim is received at least 24 hours before the end of the previously approved course of treatment. Otherwise, the time limits are the same as for Urgent Care Claims.

E. How Claims are Paid

If a claim is approved, in whole or in part, and a Covered Person has authorized payments to a provider in writing, all or a portion of any eligible expenses due to a provider will be paid directly to the provider; otherwise payment will be made directly to the Covered Person. Third parties who have purchased or been assigned benefits by Physicians or other providers will *not* be reimbursed directly by the Plan.

F. Internal Appeals and External Review of Denied Claims

If a claim is denied in whole or in part, a Covered Person may file an internal appeal of the adverse benefit determination. In making an appeal or request for external review, the Covered Person has the right to designate an authorized representative to act on the Covered Person's behalf for the purposes of the appeal or request for external review. See *Designating an Authorized Representative* at the beginning of this section.

Before filing an appeal, a Covered Person may first want to contact the Claim Administrator for medical claims or the Prescription Benefit Manager for prescription claims at the phone number(s) as shown below in (3) *How and Where to Submit Appeals* to verify that the claim was correctly processed under the terms of the Plan, however, the Covered Person is not required to do so.

Initial internal appeals must be filed within 180 days of the initial claim denial; second internal appeals must be filed within 60 days of the initial appeal denial; requests for external review (available for rescissions and claim denials based on medical judgment) must be filed within 4 months of the second internal appeal denial, or in cases involving Urgent Care, may be filed upon receipt of the initial claim denial. Any appeal or request for external review received after these deadlines will be denied. Chart B below shows details of the deadlines for filing appeals and making determinations upon review**.**

How initial and second internal appeals or requests for external review (if applicable) can be filed depends on the type of appeal or request for external review:

(1) Urgent Care Claim appeals or requests for external review may be submitted either verbally or in writing by calling or faxing the Claim Administrator for medical claims or verbally by calling the Prescription Benefit Manager for prescription claims as shown below in (3) *How and Where to Submit Appeals*. Upon request, Urgent Care Claim denials based on a medical judgment may be submitted for external review either upon receipt of the initial claim denial, after the first internal appeal or after completing the internal appeals process.

(2) *Non-Urgent Care, Pre-Service and Post-Service Claim* appeals or requests for external review must be in writing and must be submitted to the Claim Administrator for medical claims. Call the Prescription Benefit Manager for prescription appeals as shown below in (3) How and Where to Submit Appeals.

(3) *How and Where to Submit Appeals*

Urgent Care Claim, Non-Urgent Care Claim and Post-Service Claim appeals or requests for external review may be submitted to the Claim Administrator or Prescription Benefit Manager using one of the following methods:

Medical Appeals	
Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 (800) 532-7575 **Mailing Address:** Health Plans, Inc. P.O. Box 5199 Westborough, MA 01581	**Method:** ▪ Telephone (Available only for filing Urgent Care Claim appeals or requests for expedited external review) ▪ U.S. Mail ▪ Hand delivery ▪ Facsimile (FAX):(508) 329-4812
Prescription Inquiries/Prior Authorization/Appeals	
Covered Persons should contact the Prescription Benefit Manager directly at the telephone number listed on his/her ID card for directions on submitting appeals.	

Written appeals and requests for external review *must* include the following information:

(1) The patient's name

(2) The patient's Plan identification number

(3) Sufficient information to identify the claim or claims being appealed, such as the date of service, provider name, procedure (if known) and claim number (if available)

(4) A statement that the Covered Person (or authorized representative on behalf of the Covered Person) is filing an appeal or request for external review

In making an appeal or request for external review, the Covered Person has the right to:

- Review pertinent documents and submit issues and comments in writing.
- Request the billing and diagnosis codes related to the claim if the Covered Person believes a coding error may have caused the denial.
- Automatically receive any new or additional evidence or rationale considered, relied upon or generated by the Plan in connection with the claim as soon as possible so as to provide the Covered Person with reasonable time to respond before the final internal determination is issued.
- Designate an authorized representative to act on the Covered Person's behalf for the purposes of the appeal or request for external review.

- Submit written comments, documents, records, or any other matter relevant to his or her appeal or request for external review, even if the material was not submitted with the initial claim.

- Have reasonable access to, and copies of, all documents, records, and other information relevant to his or her appeal or request for external review, upon request and free of charge.

All appeals or requests for external review will be given a review that takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the appeal or request for external review, regardless of whether such information was submitted or considered in the initial benefit determination. In addition, the review will not afford deference to the initial adverse benefit determination, and the review decision will be made by individuals who were not involved in the initial claim denial and who are not subordinates of those who made the initial determination. If the denial was based on a medical judgment, the appeal or request for external review will be reviewed by a health care professional retained by the Plan who did not participate in the initial denial.

If the initial appeal is denied, the Covered Person will be given the specific reasons for the denial, with reference to the applicable Plan provision, rule, guideline, protocol or criteria upon which the denial was based. In the event that an initial appeal is denied, the Covered Person will have 60 days to request a second appeal. Alternatively, in cases involving Urgent Care Claim denials based on medical judgment, a Covered Person may forego the second internal appeal and request an external review. In filing a second appeal, the Covered Person must follow the procedures specified under (a)-(d) above, and will have the same rights as specified for the initial appeal. The second appeal will be reviewed by the Plan Administrator who holds authority under the Plan to make factual findings and to interpret Plan provisions regarding the payment of benefits**.**

If the second appeal is denied, the Covered Person will be given the specific reasons for the denial, with reference to the applicable Plan provision, rule, guideline, protocol or criteria upon which the denial was based. In the event that a second appeal is denied, and the denial involved a rescission or was based in whole or in part on medical judgment, the Covered Person will have 4 months to request an external review. In filing a request for an external review, the Covered Person must follow the procedures specified above, and will have the same rights as specified for the initial and second appeal. The Plan will conduct a preliminary review of the request to determine if the claim is eligible for external review and will provide timely notification to the Covered Person, in accordance with the requirements of federal law, as to whether the claim is eligible and whether any additional information is needed if the request is incomplete. If the claim is eligible for external review, the Plan will assign the review to an IRO on a random basis, rotating assignments among IROs. The IRO will review the Plan's denial "de novo" and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO's determination will be binding on the Plan and the Covered Person, except to the extent that other remedies are available under state or federal law. If the IRO overturns the Plan's

denial, the Plan will provide coverage or payment for the services regardless of whether the Plan intends to seek other remedies available under state or federal law.

For appeals of denials based on reasons other than rescissions or medical judgment, the second internal appeal is the final appeal available to the Covered Person and there is no further review available under the Plan. However, Covered Persons may have other remedies available under state or federal law, such as filing a lawsuit.

Any legal action against the Plan must be brought within the time periods described under the *General Provisions/Limitations on Actions* section of this Summary Plan Description.

CHART B – Time Limits Regarding Initial and Internal Second Appeals and Request for External Review						
Type of Claim	**Maximum period for Covered Person to file initial internal appeal after initial denial**	**Maximum period for issuing determination regarding initial appeal**	**Maximum period for Covered Person to file second internal appeal following denial of initial appeal in whole or in part**	**Maximum period for issuing determination regarding second appeal**	**Maximum period for Covered Person to file request for external review following denial of final appeal***	**Maximum period for issuing determination regarding external review**
URGENT CARE CLAIMS (including urgent concurrent care claims)	180 days	72 hours for both initial determination and expedited external review, if eligible and requested	60 days	72 hours	For denials involving medical judgment, Covered Persons may request expedited external review upon the initial claim denial, upon the first appeal denial, or may request external review within 4 months of the final internal appeal determination	72 hours
NON-URGENT CONCURRENT CARE AND PRE-SERVICE CLAIMS	180 days	15 days	60 days	15 days	4 months	45 days
POST-SERVICE CLAIMS	180 days	30 days	60 days	30 days	4 months	45 days

*available for rescissions and denials based on medical judgment

Statement of Rights

Participants in this Plan are entitled to certain rights and protection. all Plan participants will be entitled to:

(1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents governing the Plans including insurance contracts and collective bargaining agreements (if any);

(2) Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan including insurance contracts and collective bargaining agreements, if applicable, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies;

(3) Receive a summary of the Plan's annual financial report if the Plan is required to distribute such a summary annual financial report; and

No one, including his or her employer, his or her union (if any), or any other person, may fire the individual or otherwise discriminate against the individual in any way to prevent the individual from obtaining benefits under the Plan.

If his or her claim for a benefit under this Plan is denied in whole or in part the individual must receive a written explanation of the reason for the denial. The individual has the right to have the Plan review and reconsider his or her claim.

If the individual has a claim for benefits that is denied or ignored, in whole or in part, the individual may be able to request an external review or file suit in a state or federal court after exhausting the internal appeals process described in this Article. There may be exceptions to the requirements that individuals exhaust the internal appeals process before seeking external review or pursuing legal remedies if the Plan does not adhere to the procedural standards for claims and appeals described under this Article in a manner which is compliant with the Patient Protection and Affordable Care Act.

Any legal action against the Plan must be brought within the time periods described in the General Provisions/Limitations on Actions section of this Summary Plan Description.

If the individual has any questions about this Plan, the individual should contact the Plan Administrator.

IN WITNESS WHEREOF, the Employer has caused this Eastern Catholic Benefit Plan Summary Plan Description to be executed by its duly authorized representative.

Metropolitan Archdiocese of Pittsburgh, Byzantine Rite

July 22, 2021
Date

By: William C Skurla
Authorized Signature

William C Skurla
Print Name

Metropolitan Archbishop of Pittsburgh
Title

EASTERN CATHOLIC BENEFIT PLAN
EMPLOYEE GROUP MEDICAL PLAN
AMENDMENT #1 TO THE
JANUARY 1, 2021 SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2022

The Plan is amended in accordance with the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA) to cover Emergency Care, Out-of-Network air ambulance services and certain non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility at the In-Network level of benefits, subject to the Qualifying Payment Amount; revise the definition of Allowed Amount and Emergency Care and add the definition of Qualifying Payment Amount; include continuity of care provisions for when a provider is no longer In-Network; and include final internal appeal denials related to compliance with the NSA as eligible for external review.

This Plan is also amended to include the following updates: update the URL for the HPI website; update orthotics benefit to include coverage for foot orthotics; refer Covered Persons to contact the Pharmacy vendor for assistance with formulary drug lists; and update the Plan's right of subrogation and reimbursement to ensure that the Plan is indemnified against attorney's fees, costs, or other expenses related to the recovery of funds. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Summary Plan Description is hereby amended as follows:

SECTION I, ESTABLISHMENT OF PLAN; The Plan is hereby amended as follows:

The HPI website URL is updated to www.hpiTPA.com. All references to this website are updated throughout the document.

SECTION III, DEFINITIONS; The definitions of **Allowed Amount** and **Emergency Care** are hereby **deleted** and **replaced** in their entirety with the following:

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

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

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

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

SECTION III, DEFINITIONS; The definition of **Qualifying Payment Amount** is hereby **added** in its entirety:

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

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

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

SECTION IV, SCHEDULE OF MEDICAL BENEFITS (Plan 1, Plan 2, and Plan 6), Other Services & Supplies:

- **Orthotics** is hereby **deleted** and **replaced** in its entirety with the following:

PLAN 1

OTHER SERVICES & SUPPLIES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for air ambulance services rendered by an Out-of-Network Provider of air ambulance services; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Orthotics (Includes foot orthotics; s*ee* Medical Benefits *section for other limitations*)	100%	80% Allowed Amount (after Deductible)

PLAN 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for air ambulance services rendered by an Out-of-Network Provider of air ambulance services; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Orthotics (Includes foot orthotics; s*ee* Medical Benefits *section for other limitations*)	90% (after Deductible)	70% Allowed Amount (after Deductible)

PLAN 6

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for air ambulance services rendered by an Out-of-Network Provider of air ambulance services; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Orthotics (Includes foot orthotics; s*ee* Medical Benefits *section for other limitations*)	80% (after Deductible)	60% Allowed Amount (after Deductible)

SECTION V, MEDICAL BENEFITS, A. Benefit Levels;

- **In-Network Providers, Out-of-Network Providers** and **Traveling Benefit** are hereby **deleted** and **replaced** in their entirety with the following; and **No Surprises Billing** and **Continuity of Care** provisions are hereby **added** in their entirety with the following:

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

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

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

  When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon,

hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's Out-of-Network level of benefits, subject to the Allowed Amount.

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

Traveling benefit – If a Covered Person is traveling out of country and requires medical treatment from an Out-of-Network Provider (excluding when a Covered Person traveled to such location for the primary purpose of obtaining medical services, drugs or supplies), benefits shall be payable at In-Network Provider Co-payment and Coinsurance levels subject to the Allowed Amount or Qualifying Payment Amount, as applicable (after satisfaction of the applicable Calendar Year Deductible).

- **Continuity of Care -** In the event a Covered Person is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Covered Person shall have the following rights to continuation of care.

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

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

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

SECTION V, MEDICAL BENEFITS, C. Covered Services:

- **(1) Prescription Drugs;** The following provision is hereby **added** in its entirety:

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

- **(4) Physician Services; (h) Surgery (Inpatient/Outpatient/Office)** is hereby **deleted** and **replaced** in its entirety with the following:

  (h) Surgery (Inpatient/Outpatient/Office)

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

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

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

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

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

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

- **(10) Other Services and Supplies; Orthotics** is hereby **deleted** and **replaced** in its entirety with the following:

  Orthotics

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

SECTION XII, THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT, C. Right of Reimbursement, paragraph (2) is hereby **deleted** and **replaced** in its entirety with the following:

C. Right of Reimbursement

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

SECTION XV, CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS is hereby amended as follows:

Final internal appeal denials related to compliance with the No Surprises Act of the Consolidated Appropriations Act of 2021 are added as denials eligible for external review.

Accepted by:
Metropolitan Archdiocese of Pittsburgh, Byzantine Rite

+ William C Skurla — Metropolitan Archbishop of Pittsburgh

Authorized Signature — **Title**

William C Skurla — April 20, 2022

Print Name — **Date**

METROPOLITAN ARCHDIOCESE OF PITTSBURGH DBA EASTERN CATHOLIC BENEFIT PLAN
EMPLOYEE GROUP
MEDICAL BENEFIT PLAN(S)
SUMMARY OF MATERIAL MODIFICATIONS

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

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

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

- Coverage of testing authorized under federal law and diagnosis for COVID-19 without any cost sharing (e.g. deductibles, copayments or coinsurance) or prior authorization or other medical management requirements. This includes in- and out-of-network telehealth visits, office visits, ER visits and urgent care visits related to determining the need for a test or the actual test, and any related medical services during that time**. Effective January 1, 2021.**
- Payment to testing providers according to the network contracted rate. In the absence of a negotiated rate for out-of-network providers, payment will be based on the price posted on the provider's web site**. Effective January 1, 2021.**

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

- Coverage of COVID-19 preventive care and/or vaccinations that may become available with cost sharing waived within 15 days of recommendation for such services issued by either the United States Preventive Services Task Force (USPSTF) or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. **Effective January 1, 2021.**

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

Continued coverage under paid leave provisions of the Families First Coronavirus Response Act

- Continued eligibility for coverage for employees and covered dependents to the extent that the employee qualifies for paid leave under the provisions of the Emergency Paid Sick Leave Act and/or the Paid FMLA/Emergency Family and Medical Leave Expansion Act, as amended, beginning on and after April 1, 2020. **Effective January 1, 2021.**

Accepted by:
Metropolitan Archdiocese of Pittsburgh DBA Eastern Catholic Benefit Plan

William C Skurla
Authorized Signature

Archbishop & President
Title

Archbishop William C. Skurla
Print Name

05/13/2022
Date

EASTERN CATHOLIC BENEFIT PLAN
EMPLOYEE GROUP MEDICAL PLAN
AMENDMENT #1 TO THE
JANUARY 1, 2021 SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2022

The Plan is amended in accordance with the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA) to cover Emergency Care, Out-of-Network air ambulance services and certain non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility at the In-Network level of benefits, subject to the Qualifying Payment Amount; revise the definition of Allowed Amount and Emergency Care and add the definition of Qualifying Payment Amount; include continuity of care provisions for when a provider is no longer In-Network; and include final internal appeal denials related to compliance with the NSA as eligible for external review.

This Plan is also amended to include the following updates: update the URL for the HPI website; update orthotics benefit to include coverage for foot orthotics; refer Covered Persons to contact the Pharmacy vendor for assistance with formulary drug lists; and update the Plan's right of subrogation and reimbursement to ensure that the Plan is indemnified against attorney's fees, costs, or other expenses related to the recovery of funds. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Summary Plan Description is hereby amended as follows:

SECTION I, ESTABLISHMENT OF PLAN; The Plan is hereby amended as follows:

The HPI website URL is updated to www.hpiTPA.com. All references to this website are updated throughout the document.

SECTION III, DEFINITIONS; The definitions of **Allowed Amount** and **Emergency Care** are hereby **deleted** and **replaced** in their entirety with the following:

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

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

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

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

SECTION III, DEFINITIONS; The definition of **Qualifying Payment Amount** is hereby **added** in its entirety:

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

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

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

SECTION IV, SCHEDULE OF MEDICAL BENEFITS (Plan 1, Plan 2, and Plan 6), Other Services & Supplies:

- **Orthotics** is hereby **deleted** and **replaced** in its entirety with the following:

PLAN 1

OTHER SERVICES & SUPPLIES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for air ambulance services rendered by an Out-of-Network Provider of air ambulance services; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Orthotics (Includes foot orthotics; s*ee* Medical Benefits *section for other limitations*)	100%	80% Allowed Amount (after Deductible)

PLAN 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for air ambulance services rendered by an Out-of-Network Provider of air ambulance services; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Orthotics (Includes foot orthotics; s*ee* Medical Benefits *section for other limitations*)	90% (after Deductible)	70% Allowed Amount (after Deductible)

PLAN 6

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for air ambulance services rendered by an Out-of-Network Provider of air ambulance services; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.		
Orthotics (Includes foot orthotics; s*ee* Medical Benefits *section for other limitations*)	80% (after Deductible)	60% Allowed Amount (after Deductible)

SECTION V, MEDICAL BENEFITS, A. Benefit Levels;

- **In-Network Providers, Out-of-Network Providers** and **Traveling Benefit** are hereby **deleted** and **replaced** in their entirety with the following; and **No Surprises Billing** and **Continuity of Care** provisions are hereby **added** in their entirety with the following:

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

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

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

  When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon,

hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's Out-of-Network level of benefits, subject to the Allowed Amount.

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

Traveling benefit – If a Covered Person is traveling out of country and requires medical treatment from an Out-of-Network Provider (excluding when a Covered Person traveled to such location for the primary purpose of obtaining medical services, drugs or supplies), benefits shall be payable at In-Network Provider Co-payment and Coinsurance levels subject to the Allowed Amount or Qualifying Payment Amount, as applicable (after satisfaction of the applicable Calendar Year Deductible).

- **Continuity of Care -** In the event a Covered Person is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Covered Person shall have the following rights to continuation of care.

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

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

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

SECTION V, MEDICAL BENEFITS, C. Covered Services:

- **(1) Prescription Drugs;** The following provision is hereby **added** in its entirety:

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

- **(4) Physician Services; (h) Surgery (Inpatient/Outpatient/Office)** is hereby **deleted** and **replaced** in its entirety with the following:

  (h) Surgery (Inpatient/Outpatient/Office)

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

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

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

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

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

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

- **(10) Other Services and Supplies; Orthotics** is hereby **deleted** and **replaced** in its entirety with the following:

  Orthotics

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

SECTION XII, THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT, C. Right of Reimbursement, paragraph (2) is hereby **deleted** and **replaced** in its entirety with the following:

C. Right of Reimbursement

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

SECTION XV, CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS is hereby amended as follows:

Final internal appeal denials related to compliance with the No Surprises Act of the Consolidated Appropriations Act of 2021 are added as denials eligible for external review.

Accepted by:
Metropolitan Archdiocese of Pittsburgh, Byzantine Rite

+ William C Skurla — Metropolitan Archbishop of Pittsburgh

Authorized Signature — **Title**

William C Skurla — April 20, 2022

Print Name — **Date**

EASTERN CATHOLIC BENEFIT PLAN
EMPLOYEE GROUP MEDICAL PLAN
AMENDMENT #2 TO THE
JANUARY 1, 2021 SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2023

This Plan is amended to include the following updates: revise minimum age requirements in accordance with U.S. Preventive Services Task Force Recommendations (USPSTF) for lung cancer screenings and routine colorectal cancer screenings; clarify that coverage for gene therapy is excluded under the Plan; revise the Plan to allow for Termination of Pregnancy only in circumstances in which the life of the mother would be endangered; add new family member Exchange enrollment event under permissible Qualifying Change in Status events; and include clarification on how claims' payment is administered when a Covered Person is not eligible for Medicare. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Summary Plan Description is hereby amended as follows:

SECTION IV. SCHEDULE OF MEDICAL BENEFITS:

- **USPSTF Recommendations** for **Lung Cancer** and **Colorectal Screenings** are **updated** as follows:
  - Lung Cancer Screenings - decrease minimum age from 55 to 50
  - Routine Colorectal Cancer Screenings - decrease minimum age from 50 to 45

- **Termination of Pregnancy** is hereby **added** in its entirety in its respective alphabetical order with the following:

Plan 1

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Termination of Pregnancy (Covered only in circumstances in which the life of the mother would be endangered by continuing the pregnancy to term, as documented by the treating Physician)	100%	80% Allowed Amount (after Deductible)

Plan 2

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Termination of Pregnancy (Covered only in circumstances in which the life of the mother would be endangered by continuing the pregnancy to term, as documented by the treating Physician)	90% (after Deductible)	70% Allowed Amount (after Deductible)

Plan 6

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Termination of Pregnancy (Covered only in circumstances in which the life of the mother would be endangered by continuing the pregnancy to term, as documented by the treating Physician)	80% (after Deductible)	60% Allowed Amount (after Deductible)

SECTION V. MEDICAL BENEFITS, D. Covered Services, Termination of pregnancy is **added** in its entirety in its respective alphabetical order with the following:

- **Termination of pregnancy**

  Covered only in circumstances in which the life of the mother would be endangered by continuing the pregnancy to term, as documented by the treating Physician

SECTION VI. MEDICAL LIMITATIONS AND EXCLUSIONS, Gene therapy is **added** in its entirety in its respective alphabetical order with the following:

- **Gene therapy**

SECTION VII. ELIGIBILITY, ENROLLMENT AND PARTICIPATION, B. Enrollment, (3) Qualified Change in Status; the following **Qualified Change in Status** event is hereby **added** in its entirety:

- One or more related individuals are eligible for a special enrollment period to enroll in a Qualified Health Plan (QHP), or one or more already-covered related individuals seek to enroll in a QHP during the Exchange's annual open enrollment period, and the election change corresponds to the intended QHP enrollment for new coverage effective beginning no later than the day immediately following the last day of the revoked coverage.

SECTION VIII. COORDINATION OF BENEFITS, H. Covered Persons Not Eligible for Medicare is hereby **added** in its entirety with the following, and subsequent sections are reordered accordingly:

H. Covered Persons Not Eligible for Medicare

When a Covered Person is not eligible for Medicare because he/she:

- Did not work in employment covered by Social Security/Medicare;
- Does not qualify through the work history of a current, former, or deceased spouse,

benefits under this Plan will be paid without any coordination with Medicare.

Accepted by:
Metropolitan Archdiocese of Pittsburgh, Byzantine Rite

William C. Skurla
Authorized Signature

Archbishop / President
Title

William C. Skurla
Print Name

06/29/2023
Date

Version 1.2; 06/29/2023

EASTERN CATHOLIC BENEFIT PLAN
EMPLOYEE GROUP MEDICAL PLAN
AMENDMENT #3 TO THE
JANUARY 1, 2021 SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2024

This Plan is amended to include the following updates: revise the Prescription Benefit Manager name from Southern Scripts to Liviniti and provisions of the Variable Copay™ Program. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Summary Plan Description is hereby amended as follows:

The **Prescription Benefit Manager** name is hereby **updated** as follows:

- Prescription Drug Benefit – Administered by Liviniti

SECTION IV. SCHEDULE OF MEDICAL BENEFITS:

The **Prescription Benefit Manage**r name is hereby **updated** as follows:

- Prescription Drug Benefit – Administered by Liviniti

SECTION V. MEDICAL BENEFITS, C. Covered Services, (1) Prescription Drugs, Variable Copay Program is hereby **deleted** and **replaced** in its entirety with the following:

Variable Copay Program

The Plan has adopted the Liviniti Variable Copay™ Program to help Covered Persons who utilize manufacturer Co-payment programs save money on prescription drugs. Under the Variable Copay™ Program, the out-of-pocket cost for prescription drugs may be reduced or eliminated by a drug manufacturer's Co-payment subsidy. If a Covered Person is eligible to receive a manufacturer Co-payment subsidy for a drug, his or her Co-payment obligation for that drug will be the maximum manufacturer Co-payment subsidy for that drug. Any manufacturer Co-payment subsidy obtained under the Variable Copay™ Program will not accumulate toward your Deductible or Out-of-Pocket costs. Note: if a Covered Person is eligible for a manufacturer Co-payment subsidy for a drug but fails to obtain the subsidy, his or her Co-payment obligation – and the out-of-pocket cost he or she may be required to pay – will be the maximum manufacturer Co-payment subsidy for that drug. If a Covered Person is not eligible to receive a manufacturer Co-payment subsidy, his or her Co-payment obligation will be the Co-payment amount listed for the drug in the standard formulary under the Plan.

Manufacturer eligibility requirements are subject to change without notice. As a result, in certain instances, drugs may no longer be available under the Variable Copay™ Program (referred to as "Excepted Drugs"). Covered Persons are solely responsible for their cost-sharing obligation for Excepted Drugs; however, cost-sharing assistance may be available to the Covered Person from a third party (such as a drug manufacturer). Please note that any cost-sharing assistance received with respect to an Excepted Drug will accumulate toward a Covered Person's Deductible or Out-of-Pocket Maximum, subject to satisfying the statutory minimum Deductible for purposes of the federal tax rules governing Health Savings Account (HSA) eligibility if a Covered Person is enrolled in an HSA-qualifying high-deductible health plan.

For additional information on the Excepted Drugs subject to a drug-specific cost-sharing obligation under the Plan or any additional information regarding to the prescription drug plan, please visit www.variablecopay.com or contact Liviniti at the telephone number on your ID card.

Accepted by:
Metropolitan Archdiocese of Pittsburgh, Byzantine Rite

+William C Skurla
Authorized Signature

Archbishop & President
Title

Archbishop William C. Skurla
Print Name

2/22/2024
Date

Version 1.0; 02/12/2024

EASTERN CATHOLIC BENEFIT PLAN
EMPLOYEE GROUP MEDICAL PLAN
AMENDMENT #4 TO THE
JANUARY 1, 2021 SUMMARY PLAN DESCRIPTION
EFFECTIVE: OCTOBER 1, 2024

This Plan is amended to add the RxCompass Specialty Pharmacy Medical Expense Reimbursement Program. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Summary Plan Description is hereby amended as follows:

SECTION IV. SCHEDULE OF MEDICAL BENEFITS:

- The first box of each of the Prescription Drug Benefit charts are **deleted** and **replaced** as follows:

PLAN 1

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY LIVINITI	
Prescription Drug Expense & Mail Order Option Note: Prescription drug Co-payments accumulate toward the Out-of-Pocket Maximum (shown below). Once the Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% for the balance of the Calendar Year. Tobacco cessations products are covered at 100% Substitution of a generic equivalent medication is required; if a Covered Person requests the brand name medication be filled, the Covered Person pays the difference between the brand and generic drug, in addition to the brand name Co-payment, when a generic drug is available. The Plan has adopted the RxCompass Program to help Covered Persons address the issues of high-cost medications by providing multiple solutions for sourcing drugs, through the RxCompass pathways. If a prescription drug is eligible for coverage through the RxCompass Program, that drug will not be covered under the Plan. Additional information on the RxCompass program is available at myrxcompass.com.	**Retail Card Program – You Pay:** (Up to a 31 day supply) $10 Co-payment per generic drug; $20 Co-payment per preferred brand name drug; $40 Co-payment per non-preferred brand name drug; $80 Co-payment per specialty drug **Mail Order Pharmacy – You Pay:** (Up to a 90 day supply) $20 Co-payment per generic drug; $40 Co-payment per preferred brand name drug; $80 Co-payment per non-preferred brand name drug Preventive drugs are covered with no cost-sharing. Contraceptive medications are not covered.

PLAN 2 PPO

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY LIVINITI	
Prescription Drug Expense & Mail Order Option Note: Prescription drug Co-payments accumulate toward the Out-of-Pocket Maximum (shown below). Once the Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% for the balance of the Calendar Year. Tobacco cessations products are covered at 100% Substitution of a generic equivalent medication is required; if a Covered Person requests the brand name medication be filled, the Covered Person pays the difference between the brand and generic drug, in addition to the brand name Co-payment, when a generic drug is available. The Plan has adopted the RxCompass Program to help Covered Persons address the issues of high-cost medications by providing multiple solutions for sourcing drugs, through the RxCompass pathways. If a prescription drug is eligible for coverage through the RxCompass Program, that drug will not be covered under the Plan. Additional information on the RxCompass program is available at myrxcompass.com.	**Retail Card Program – You Pay:** (Up to a 30 day supply) $10 Co-payment per generic drug; $20 Co-payment per preferred brand name drug; $20 Co-payment per non-preferred brand name drug Specialty Drugs are paid as shown above **Mail Order Pharmacy – You Pay:** (Up to a 90 day supply) $20 Co-payment per generic drug; $40 Co-payment per preferred brand name drug; $40 Co-payment per non-preferred brand name drug Preventive drugs are covered with no cost sharing. Contraceptive medications are not covered.

PLAN 6 PPO

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY LIVINITI	
Prescription Drug Expense & Mail Order Option Note: Prescription drug Co-payments and Coinsurance accumulate toward the prescription drug Out-of-Pocket Maximums. Once the prescription drug Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% for the balance of the Calendar Year. Tobacco cessations products are covered at 100% Substitution of a generic equivalent medication is required; if a Covered Person requests the brand name medication be filled, the Covered Person pays the difference between the brand and generic drug, in addition to the brand name Co-payment, when a generic drug is available. The Plan has adopted the RxCompass Program to help Covered Persons address the issues of high-cost medications by providing multiple solutions for sourcing drugs, through the RxCompass pathways. If a prescription drug is eligible for coverage through the RxCompass Program, that drug will not be covered under the Plan. Additional information on the RxCompass program is available at myrxcompass.com.	**Retail Card Program – You Pay:** (Up to a 30 day supply) $15 Co-payment per generic drug; $30 Co-payment per preferred brand name drug; $50 Co-payment per non-preferred brand name drug **Specialty Drug – You Pay:** (Up to a 30 day supply) 10% Coinsurance up to a maximum of $150 per generic drug; 20% Coinsurance up to a maximum of $150 per preferred brand name drug; 20% Coinsurance up to a maximum $250 per non-preferred brand name drug. **Mail Order Pharmacy – You Pay:** (Up to a 90 day supply) $35 Co-payment per generic drug; $75 Co-payment per preferred brand name drug; $125 Co-payment per non-preferred brand name drug Preventive drugs are covered with no cost sharing. Contraceptive medications are not covered.

SECTION V. MEDICAL BENEFITS, C. Covered Services, (1) Prescription Drugs is amended by the **addition** of the following new item (i) under "Prescription drug charges not covered, including but not limited to":

(i) Prescriptions which are eligible for coverage under the RxCompass Program, regardless of whether the Covered Person participates in the process to fill the prescription through the RxCompass Program.

Accepted by:
Eastern Catholic Benefit Plan

William C. Skurla
Authorized Signature

Archbishop & President
Title

Archbishop William C. Skurla
Print Name

September 24, 2024
Date

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