UnityPoint Health

Plan Document and Summary Plan Description

UnityPoint Health- Pekin Medical Benefit Plan
HSA Plan

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Summary Plan Description Effective Date: The later of January 1, 2018 and the Covered Person's effective date of coverage under the Plan.

Schedule of Payments

See Sections III. and IV. of this SPD for additional information about covered services and limitations.

The Network Benefits are intended to constitute a high deductible health plan under Internal Revenue Code section 223.

The amount that the Plan pays for covered services is listed below. The Covered Person is responsible for the specified dollar amount and/or percentage of charges that the Plan does not pay.

Coverage may vary according to your network or provider selection.

You must receive services from your network providers, except for emergency care, chiropractic care and routine eye exams as described in the Schedule of Payments.

These definitions apply to the Schedule of Payments. They also apply to the SPD.

Charge: For covered services delivered by participating network providers or network referral providers, this is the provider's discounted charge for a given medical/surgical service, procedure or item.

A charge is incurred for covered ambulatory medical, inpatient professional fees, and surgical services on the date the service or item is provided. A charge is incurred for covered inpatient facility fees on the date of admission to a hospital. To be covered, a charge must be incurred on or after the Covered Person's effective date and on or before the termination date.

Copayment/Coinsurance: The specified dollar amount, or percentage, of charges incurred for covered services, which the Plan does not pay, but which a Covered Person must pay, each time a Covered Person receives certain medical services, procedures or items. The Plan's payment for those covered services or items begins after the copayment or coinsurance is satisfied. Covered services or items requiring a copayment or coinsurance are specified in this SPD.

The amount which is listed as a percentage of charges or coinsurance is based on the network providers' discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements. However, if a network providers' discounted charge for a service or item is less than the flat dollar copayment, you will pay the network providers' discounted charge. A copayment or coinsurance is due at the time a service is provided, or when billed by the provider.

The copayment or coinsurance applicable for a scheduled visit with a network provider will be collected for each visit, late cancellation and failed appointment.

Deductible: The specified dollar amount of charges incurred for covered services, which the Plan does not pay, but a Covered Person or a covered family has to pay first in a calendar year. The Plan's payment for those services or items begins after the deductible is satisfied. The amount of charges that apply to the deductible are based on the network providers' discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule for case rate or withhold arrangements.

	Amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, debit cards or other forms of direct reimbursement to a Covered Person for a product or service, may not apply toward your deductible.
Lifetime Maximum Benefit:	The specified coverage limit actually paid for services and/or charges for a Covered Person. Payment for benefits under the Plan ceases for that Covered Person when the lifetime maximum benefit is reached. The Covered Person has to pay for any subsequent charges.
Out-of-Pocket Expenses:	You pay the specified copayments/coinsurance and deductibles applicable for particular services, subject to the out-of-pocket limit described below. These amounts are in addition to employee contributions.
Out-of-Pocket Limit:	You pay the copayments/coinsurance and deductibles for covered services, to the individual or family out-of-pocket limit. Thereafter, 100% of charges incurred are covered under the Plan for all other covered services for the rest of the calendar year. You pay amounts greater than the out-of-pocket limit if you exceed any visit or day limits Amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, debit cards or other forms of direct reimbursement to a Covered Person for a product or service, may not apply as an out-of-pocket expense. You are responsible to keep track of the out-of-pocket expenses. Contact Member Services for assistance in determining the amount paid by the Covered Person for specific eligible services received. Claims for reimbursement under the out-of-pocket limit provisions are subject to the same time limits and provisions described under the "Claims Procedures" section of the SPD.
Preferred Out-of-Network Provider:	Except for emergency care, chiropractic care, and routine eye exams, this is the provider you must see to receive coverage for Out-of-Network services. The Plan must approve these services in advance to be covered under the Plan. The Preferred Out-of-Network Provider for the Plan is the University of Iowa. Please refer to the "About the Network" section of this SPD for more information.

	Network Benefits
Individual Calendar Year Deductible (applies to an employee enrolled for single coverage)	$2,000
Family Calendar Year Deductible (applies to an employee and dependents enrolled for family coverage)	$3,500
Individual Calendar Year Out-of-Pocket Limit (applies to an employee enrolled for single coverage)	$4,000
Family Calendar Year Out-of-Pocket Limit (applies to an employee and dependents enrolled for family coverage)	$7,000

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

	***Network Benefits**
A. AMBULANCE AND MEDICAL TRANSPORTATION	80% of the charges incurred.
B. BEHAVIORAL HEALTH SERVICES	
Mental Health and Chemical Health benefits are included in this Plan. Precedence is the administrator of these benefits and claims are paid by GPS. **Prior Authorization Requirements:** Inpatient services, day treatment and intensive outpatient services, partial hospitalization services, opiate replacement therapy and psychotherapy and nursing services provided in the home require prior authorization. The prior authorization should be requested as soon as it is scheduled, but no later than the day of admission. In the event of a behavioral health emergency, you should contact Precedence for a hospital utilization management review within two business days of the admission. If prior authorization is not made, services will not be covered. Provider office visits do not require prior authorization requirements. **To request prior authorization, please contact Precedence at: 1-800-361-1492.**	
Mental Health Services	
a. Outpatient Services, including day treatment, group therapy and intensive outpatient services	80% of the charges incurred.
b. Inpatient Services	80% of the charges incurred.
Chemical Health Services	
a. Outpatient Services, including day treatment, group therapy and intensive outpatient services	80% of the charges incurred. *The Plan covers supervised lodging at a contracted organization for Covered Persons actively involved in an affiliated licensed chemical dependency day treatment or intensive outpatient program for treatment of alcohol or drug abuse.*
b. Inpatient Services	80% of the charges incurred.
C. CHIROPRACTIC SERVICES	80% of the charges incurred. *Limited to five visits per calendar year.* *For chiropractic care, you can see any chiropractic provider. You do not have to see a network provider for these services. Call Member Services at 1-888-301-0747 if you have questions or need help finding a provider.*
D. CLINICAL TRIALS	Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

*Deductible must first be satisfied.

	***Network Benefits**
E. DENTAL SERVICES	
Accidental Dental Services within the Network and Emergency Accidental Dental Services outside the Network	80% of the charges incurred. *Coverage is limited to the initial course of treatment and/or initial restoration. Services must be completed within 12 months of the date of injury to be covered.*
Medical Referral Dental Services	
a. Medically Necessary Outpatient Dental Services	80% of the charges incurred.
b. Medically Necessary Hospitalization and Anesthesia for Dental Care	80% of the charges incurred.
c. Medical Complications of Dental Care	80% of the charges incurred.
Oral Surgery	80% of the charges incurred.
Orthognathic Surgery Benefit	80% of the charges incurred.
Treatment of Cleft Lip and Cleft Palate of a Dependent Child	80% of the charges incurred.
F. DIAGNOSTIC IMAGING SERVICES *The Plan covers services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)*	
Associated with covered preventive services (MRI/CT procedures are not considered preventive)	Diagnostic imaging for preventive services is covered at the benefit level shown in the Preventive Services section.
For illness or injury	
a. Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT)	80% of the charges incurred.
b. All other outpatient diagnostic imaging services	80% of the charges incurred.
G. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES	80% of the charges incurred.
Special dietary treatment for Phenylketonuria (PKU)	80% of the charges incurred.
Oral amino acid based elemental formula if it meets medical coverage criteria	80% of the charges incurred. *No more than a 90-day supply of diabetic supplies will be covered and dispensed at a time.*

*Deductible must first be satisfied.

	***Network Benefits**
H. EMERGENCY AND URGENTLY NEEDED CARE SERVICES	
Urgently Needed care provided at network and out-of-network clinics	80% of the charges incurred.
Emergency care in a network and out-of-network hospital emergency room, including professional services of a physician	80% of the charges incurred.
Inpatient emergency care in a network or out-of-network hospital	80% of the charges incurred. *Out-of-Network professional fees will be paid at the Network Inpatient Hospital Services Benefit level if the Covered Person is admitted inpatient to a network hospital through the emergency room.*
I. HEALTH EDUCATION	100% of the charges incurred. Deductible does not apply.
J. HOME HEALTH SERVICES	
Physical therapy, occupational therapy, speech therapy, respiratory therapy, home health aide services and palliative care	80% of the charges incurred.
TPN/IV therapy, skilled nursing services, non-routine prenatal/postnatal services, and phototherapy	80% of the charges incurred. *Each 24-hour visit (or shifts of up to 24-hour visits) equals one visit and counts toward the maximum visits for all other services shown below. Any visit that lasts less than 24 hours, regardless of the length of the visit, will count as one visit toward the maximum visits for all other services shown below. All visits must be medically necessary and benefit eligible.*
Routine postnatal well child visits	80% of the charges incurred. *If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of eight visits per calendar year.* *For all other services that meet the home health services requirements described in this SPD, there is a maximum of 100 visits per calendar year. The routine postnatal well child visits do not count toward the visit limit.*

*Deductible must first be satisfied.

	***Network Benefits**
K. HOSPICE SERVICES	80% of the charges incurred. *Respite care is limited to five episodes, up to five days per episode. Inpatient hospice respite care is limited to 15 days per lifetime.*
L. HOSPITAL AND SKILLED NURSING FACILITY SERVICES	
Medical or Surgical Hospital Services	
a. Inpatient Hospital Services	80% of the charges incurred. *Each Covered Person's admission or confinement, including that of a newborn child, is separate and distinct from the admission or confinement of any other Covered Person.*
b. Outpatient Hospital, Ambulatory Care or Surgical Facility Services *(to see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see the benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy)*	80% of the charges incurred.
Skilled Nursing Facility Care	80% of the charges incurred. *Limited to a 100 day maximum per period of confinement.*
M. LABORATORY SERVICES *The Plan covers services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)*	
Associated with covered preventive services	Laboratory for preventive services is covered at the benefit level shown in the Preventive Services section.
For illness or injury	80% of the charges incurred.
N. MASTECTOMY RECONSTRUCTION BENEFIT	Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.
O. MEDICATION THERAPY DISEASE MANAGEMENT PROGRAM	100% of the charges incurred. Deductible does not apply.

*Deductible must first be satisfied.

	***Network Benefits**
P. OFFICE VISITS FOR ILLNESS OR INJURY	
Office visits	80% of the charges incurred.
Scheduled telephone visits	80% of the charges incurred.
E-visits	80% of the charges incurred.
Virtual Care	$39, then 80% of the charges incurred after deductible .
Allergy Testing	80% of the charges incurred.
Injections administered in a Physician's office	
Allergy injections	80% of the charges incurred.
All other injections	80% of the charges incurred.
Q. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY *The Plan covers services provided in a clinic. The Plan also covers physical therapy provided in an outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)*	
Rehabilitative therapy	80% of the charges incurred.
Habilitative therapy	80% of the charges incurred.
R. PRESCRIPTION DRUG SERVICES	**Drugs and medications must be part of the formulary and obtained at a network pharmacy.**
Outpatient Drugs (except as specified below)	80% of the charges incurred.
Contraceptives that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. See https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations	100% of the charges incurred. Deductible does not apply.
Drugs for Breast Cancer Prevention - for women at high risk for breast cancer who have not yet been diagnosed with the disease	100% of the charges incurred. Deductible does not apply.
Tobacco cessation products, as determined by the Plan. Must be prescribed by a licensed provider.	100% of the charges incurred. Deductible does not apply.

*Deductible must first be satisfied.

	***Network Benefits**
Mail Order Drugs	You may also get outpatient formulary prescription drugs which can be self-administered through MagellanRx mail order service. Outpatient drugs ordered through this service are covered at the benefit percent shown in Outpatient Drugs above, for up to a 90-day supply. *Specialty drugs are not available through the mail order service.*
Diabetic Supplies purchased at a pharmacy	80% of the charges incurred.
Specialty drugs which are self-administered	80% of the charges incurred. *Specialty drugs are limited to drugs on the specialty drug list and must be obtained from a designated vendor. Certain specialty drugs are required to be filled at UnityPoint at Home Specialty Pharmacy. Call UnityPoint at Home Specialty Pharmacy at 877-804-2713 for the specialty drug list.*

Unless otherwise specified above in the Prescription Drug Services section, you may receive up to a 30-day supply per prescription. Certain drugs may require prior authorization as indicated by the Pharmacy Benefit Manager. The Plan may require prior authorization for the drug and also the site where the drug will be provided. All drugs are subject to utilization review process and quantity limits. New prescriptions to treat certain chronic conditions are limited to a 30-day supply. In addition, certain drugs may be subject to any quantity limits applied as part of the trial program. The trial drug program applies to new prescriptions for certain drugs which have high toxicity, low tolerance, high costs and/or high potential for waste. Trial drugs are indicated on the formulary and/or the specialty drug list. Your first fill of a trial drug may be limited to less than a month supply. If the drug is well tolerated and effective, you will receive the remainder of your first month supply. Certain non-formulary drugs require prior authorization. A 90-day supply will be covered and dispensed at a time only at pharmacies that participate in the extended day supply program. No more than a 30-day supply of specialty drugs will be covered and dispensed at a time.

If you request a brand drug when there is a generic equivalent, the brand drug will be covered up to the charge that would apply to the generic drug, minus any required copayment.

If a physician requests that a brand drug be dispensed as written (DAW), and it is determined that the brand drug is medically necessary, the drug will be covered up to the charge that would apply to the brand drug.

Drugs for the treatment of sexual dysfunction are not covered.

For mail order drugs, see benefit above.

*Deductible must first be satisfied.

	***Network Benefits**
S. PREVENTIVE SERVICES Preventive Services in this section covered at 100% means items or services with a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force found at: https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations,	
1. Routine health exams and periodic health assessments	100% of the charges incurred. Deductible does not apply.
2. Child health supervision services	100% of the charges incurred. Deductible does not apply.
3. Routine prenatal care	80% of the charges incurred. *Screenings for pregnant women which are included in the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers of Disease Control and the Health Resources and Services Administration (HRSA) will be covered at 100% of the charges incurred, deductible does not apply.*
4. Routine postnatal care	80% of the charges incurred.
5. Routine screening procedures for cancer	100% of the charges incurred. Deductible does not apply.
6. Routine eye and hearing exams	100% of the charges incurred. Deductible does not apply. *For routine eye exams, you can see any optometry provider. You do not have to see a network provider for these services. For non-routine eye care, you will need to visit a network provider. Call Member Services at 1-800-301-0747 if you have questions or need help finding a provider.*
7. Adult immunizations	100% of the charges incurred. Deductible does not apply.
8. Women's preventive health services including FDA approved contraceptive methods as prescribed by a physician (see prescription drug services section for coverage of contraceptive drugs)	100% of the charges incurred. Deductible does not apply.
9. Obesity screening and management	100% of the charges incurred. Deductible does not apply.
T. TRANSPLANT SERVICES	80% of the charges incurred.

*Deductible must first be satisfied.

	***Network Benefits**
U. TRAVEL AND LODGING *Limited to travel and lodging costs when related to out-of-region UnityPoint Health specialists and inpatient or outpatient facility care when care is not available from a UnityPoint specialist or at a facility within 60 miles of the Covered Person's home.*	100% of the charges incurred. *Travel and lodging reimbursement guidelines: If traveling between 60-180 miles (one way) for services, you will receive reimbursement for mileage only. If traveling beyond 180 miles (one way) you will receive reimbursement for mileage and lodging (up to a maximum benefit of $150 per night). Travel and lodging is limited to a maximum benefit of $1,500 per trip. Examples of allowed travel and lodging expenses include hotels, motels, cars, planes, trains, and RVs.* *For information on how to be reimbursed for travel and lodging costs, call the Member Services number on your ID card..*
V. WEIGHT LOSS SURGERY OR BARIATRIC SURGERY	Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

*Deductible must first be satisfied.

SPECIFIC INFORMATION ABOUT THE PLAN

The federal government requires that the following information be furnished for the Plan:

Employer:	Pekin Memorial Hospital DBA Progressive Health Systems, Inc.
Name of the Plan:	The Plan shall be known as the UnityPoint Health – Pekin Medical Benefit Plan which provides employee and dependent medical benefits
Address of the Plan:	600 S. 13th Street Pekin, IL 61554 309-353-0946
IRS Employer Identification Number:	37-0692351
Plan Identification Number:	501
Effective Date	January 1, 2018
Original Effective date	May 1, 1978
Plan Year:	The period beginning on each January 1 in which the provisions of the Plan are in effect.
Plan Fiscal Year Ends:	December 31
Plan Sponsor: (is ultimately responsible for the management of the Plan; may employ or contract with persons or firms to perform day-to-day functions such as processing claims and performing other Plan-connected services.)	Pekin Memorial Hospital DBA Progressive Health Systems, Inc.
Participating Employer:	Pro Health, Inc. IRS Employer ID Number: 37-1117052 600 S. 13th Street Pekin, IL 61554 309-353-0946
Agent for Service of Legal Process:	Pekin Memorial Hospital DBA Progressive Health Systems, Inc. 600 S. 13th Street Pekin, IL 61554 309-353-0946
Named Fiduciary: (has the authority to control and manage the operation and administration of the Plan; has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan.)	For purposes of determining eligibility and enrollment, and for funding claims paid and all related activities and responsibilities under the Plan, Pekin Memorial Hospital DBA Progressive Health is the named fiduciary. Solely for purposes of determining coverage of claims, Group Plan Solutions Benefit Administration, a division of Pekin Insurance is the named fiduciary.
Funding:	Claims under the Plan are paid from the general assets of the Employer.

Third Party Administrator/Claims Administrator: (provides administrative services to the Plan Sponsor in connection with the operation of the Plan, such as processing of claims and other functions, as may be delegated to it.)	Group Plan Solutions Benefit Administration, a division of Pekin Insurance 2505 Court Street Pekin, IL 61558 Member Services: 888-301-0747 Fax: 855-545-7165
Utilization Review for Medical Services:	Medical Cost Management (MCM) 24-hour Precertification 888-641-5304
Behavioral Health Benefit Services Administrator: (provides administrative services for behavioral health treatment)	Precedence, Inc. 735 Federal Street, Suite 202 Davenport, IA 52803 1-800-361-1492
Case Management Prior Authorization:	Group Plan Solutions Case Management 2505 Court Street Pekin, IL 61558 Case Management: 888-301-0747 Ext. 3155
Pharmacy Benefit Manager (PBM)	MagellanRx 800-424-0472 Website: www.magellanrx.com
Network Providers:	UnityPoint Health - ACO Network
Contributions:	Please refer to the most recent enrollment material for information regarding contributions to your Plan which is hereby incorporated by this reference.

ABOUT GROUP PLAN SOLUTIONS UNITYPOINT HEALTH and YOUR EMPLOYER

Group Plan Solutions Benefit Administration, a division of Pekin Insurance (GPS) is a Third Party Administrator (TPA)

UnityPoint Health. UnityPoint Health is an Iowa non-profit corporation and care delivery system. Medical Cost Management (MCM) a utilization review company that does precertification for the Plan.

Precedence, Inc. Precedence is an Illinois limited liability company.

Employer ("Plan Sponsor"). The Employer has established a Medical Benefit Plan ("the Plan") to provide medical benefits for Covered Employees and their Covered Dependents ("Covered Persons"). The Plan is "self-insured" which means that the Plan Sponsor pays the claims from its own funding as expenses for covered services as they are incurred. The Plan is described in the Summary Plan Description ("SPD"). The Plan Sponsor has contracted with GPS to process claims and other Plan administration services. However, the Plan Sponsor is solely responsible for payment of your eligible claims.

Powers of the Plan Sponsor. The Plan Sponsor shall have all powers and discretion necessary to administer the Plan, including, without limitation, powers to: (1) establish and revise the method of accounting for the Plan; (2) establish rules and prescribe any forms required for administration of the Plan; (3) change the Plan; and (4) terminate the Plan.

The Plan Sponsor, by action of an authorized officer or committee, reserves the right to change or terminate the Plan at any time for any reason. This includes, but is not limited to, changes to contributions, deductibles, copayments, out-of-pocket maximums, benefits payable and any other terms or conditions of the Plan. The Plan Sponsor's decision to change the Plan may be due to changes in federal laws governing health and welfare benefits, the requirements of the

Internal Revenue Code or ERISA, or for any other reason. The Plan may be changed to transfer the Plan's liabilities to another plan or split the Plan into two or more parts.

The Plan Sponsor shall have the power to delegate specific duties and responsibilities. Any delegation by the Plan Sponsor may allow further delegations by such individuals or entities to whom the delegation has been made. Any delegation may be rescinded by the Plan Sponsor at any time. Each person or entity to whom a duty or responsibility has been delegated shall be responsible for only those duties or responsibilities, and shall not be responsible for any act or failure to act of any other individual or entity.

No Guarantee of Employment. The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Plan Sponsor and any Covered Employee. Nothing contained herein shall give any Covered Employee the right to be retained in the employ of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any Covered Employee, any time, nor shall it give the Plan Sponsor the right to require any Covered Employee to remain in its employ or to interfere with the Covered Employee's right to terminate his or her employment at any time.

UnityPoint Health Marks. The UnityPoint Health name and logo and all related products and service names and design marks are used under a license agreement with UnityPoint Health.

RIGHTS UNDER ERISA

As a participant under the Plan, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Sponsor's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Sponsor, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's financial report. The Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan or the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "Fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal

court. In such a case, the court may require the Plan Sponsor to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your right, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Sponsor, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue Northwest, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

RESPONSIBILITIES OF COVERED PERSONS

1. Read this Plan Document/SPD and the enrollment materials completely and comply with the stated rules and limitations.

2. Contact providers to arrange for necessary medical appointments.

3. Pay any applicable copayments, deductibles and contributions as stated in this SPD.

4. Identify yourself as a Covered Person by presenting your identification card whenever you receive covered services under the Plan.

RIGHTS UPON TERMINATION OR AMENDMENT OF THE PLAN

For a summary of Plan provisions governing benefits, rights and obligations of participants and beneficiaries under the Plan on termination of the Plan or amendment or elimination of benefit under the Plan, please consult your Employer.

I. INTRODUCTION TO THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

A. PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION ("SPD")

This Plan Document/SPD, along with the Third Party Administrator's medical coverage criteria (available by logging onto www.groupplansolutions.com or by calling Member Services), is your description of the Employer's Medical Benefit Plan ("the Plan"). It describes the Plan's benefits and limitations. Included in this Plan Document/SPD is a Schedule of Payments which states the amount payable for the covered services. Amendments which we include with this Plan Document/SPD or send you at a later date are fully made a part of this Plan Document/SPD.

This Plan Document/SPD should be read completely. Many of its provisions are interrelated; reading just one or two provisions may give you incomplete information regarding your rights and responsibilities under the Plan. Many of the terms used in this Plan Document/SPD have special meanings and are specifically defined in the Plan Document/SPD. Your Plan Document/SPD should be kept in a safe place for your future reference.

The Plan is maintained exclusively for Covered Employees and their Covered Dependents. Each Covered Person's rights under the Plan are legally enforceable. You may not assign or in any way transfer your rights under the Plan.

B. CONFLICT WITH EXISTING LAW

In the event that any provision of this Plan Document/SPD is in conflict with applicable law, that provision only is hereby amended to conform to the minimum requirements of the law.

C. IDENTIFICATION CARD

An identification card will be issued to you at the time of enrollment. You and your Covered Dependents will be asked to present your identification card, or otherwise show that you are a Covered Person, whenever you seek services. You may not permit anyone else to use your card to obtain care.

D. HOW TO USE THE NETWORK

This Plan Document/SPD describes your covered services and how to obtain them. **The Plan provides Network Benefits from which you may choose to receive covered services.** Coverage may vary according to your network or provider selection. The provisions below contain information you need to know in order to obtain covered services.

Designated Physician, Provider, Facility or Vendor. You can verify if your physicians, providers, facilities or vendors are preferred providers are authorized to provide certain covered services as described in this SPD. Call Member Services at 888-301-0747 Extension 2975 or check online by logging onto www.groupplansolutions.com and selection Member>Find a Provider to obtain provider information.

Weight loss surgery must be provided by a designated provider.

For specialty drugs that are self-administered, you must obtain the specialty drugs from a designated vendor to be covered as Network Benefits.

Network Providers. This is any one of the participating licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies, which have entered into an agreement to provide health care services to Covered Persons. **Under this Plan Document/SPD, only services received from network providers are covered benefits. Services received from out-of-network providers are not covered benefits, except for emergency care, chiropractic care and routine eye exams as described in the Schedule of Payments.**

To see what physicians and other health care providers are in your network, log onto www.groupplansolutions.com and selection Member>Find a Provider**. If you need assistance locating a physician or other health care providers in your network, please contact Member Services** at 888-301-0747 Extension 2975**.**

Out-of-Network Providers. These are licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies not participating as network providers. **Under this Plan Document/SPD, services received from out-of-network providers are not covered benefits, except for emergency care, chiropractic care and routine eye exams as described in the Schedule of Payments.** Certain services that are not available in the Network may be covered through the UnityPoint Health Out-of-Network Referral as described under "Out-of-Network Referral" in this section.

ABOUT THE NETWORK

You must receive services from network providers, except for emergency care, chiropractic care and routine eye exams as described in the Schedule of Payments.

Network. This is the network of participating network providers.

Network Clinics. These are participating clinics providing ambulatory medical services.
Out-of-Network services: The Plan must approve these services in advance to be covered under the Plan. The Preferred Out-of-Network Provider for the Plan is the University of Iowa.

Continuity of Care. In the event you must change your current primary care physician, specialty care physician or general hospital provider because that provider leaves the network or because your Employer changed health plan offerings, you may have the right to continue receiving services from your current provider for a period of time.

Conditions that qualify for this benefit are:

1. continuation of treatment through the current period of active treatment, or for up to 90 days, whichever is less, for covered persons undergoing active treatment for a chronic or acute medical condition; or
2. a specified course of treatment for a terminal illness or a related condition, for a period of up to 90 days; or
3. pregnancy beyond the first trimester of pregnancy, with such care continuing through the postpartum care related to the child birth and delivery.

Call Member Services for further information regarding continuity of care benefits.

Out-of-Network Referral. Certain services that are not available in the Network may be covered only if referred by your Network Provider and submitted to and approved by the Plan through the UnityPoint Health- ACO Out-of-Network Referral process. The Plan must approve these services to be covered under the Plan. Contact Member Services at 888-301-0747 to start the Out-of-Network referral process.**Prior Authorization.** You or your Physician may be required to obtain Prior Authorization for certain services. Prior Authorization/Precertification should be requested as soon as the medical inpatient stay or overnight observation is scheduled, but no later than one business day before admission. In the event of a medical emergency, you or your physician should contact Medical Case Management (MCM) for precertification within two business days of the admission. In the event of a behavioral health emergency, you should contact Precedence for a hospital utilization management review within two business days of the admission. You may call GPS Member Services at 888-301-0747 to determine which services require you to obtain prior authorization. .

Medical Case Management (MCM) or Precedence will determine medical necessity and appropriateness of inpatient stays or overnight observations.

Mental Health and Chemical Health Prior Authorization Requirements: Inpatient services, overnight observation stays, day treatment and intensive outpatient services, partial hospitalization services, opiate replacement therapy and psychotherapy and nursing services provided in the home require prior authorization. The prior authorization should be requested as soon as it is scheduled, but no later than the day of admission. In the event of a behavioral health emergency, you should contact Precedence for a hospital utilization management review within two business days of the admission. If prior authorization is not made, services will not be covered. Provider office visits do not require prior authorization requirements. To request prior authorization, please contact Precedence at: 1-800-361-1492.

1. **Procedure to Follow to Request Prior Authorization:**
    a. For medical emergent/urgent care, you should contact Precedence within two business days, or as soon as reasonably possible under the circumstances.
    b. For medical non-emergencies, you should contact Precedence at least two days prior to the date of service. Precedence will determine whether the services will be covered and confirm their decision by written notice within 15 days of their decision.
2. **If you fail to obtain Prior Authorization for non-emergency services, they will not be covered.**

Second Opinions for Network Services. If you question a decision or recommendation about medical care, the Plan covers a second opinion from an appropriate network provider.

Prescription Drugs and Medical Equipment. Enrolling in the Plan does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment was available previously.

E. ELIGIBILITY, EFFECTIVE DATE, LATE ENROLLMENT, SPECIAL ENROLLMENT PERIOD, SPECIAL RULES RELATING TO MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM ("CHIP"), ENROLLMENT OF NEWBORN OR NEWLY ADOPTED CHILDREN, CHANGES IN BENEFITS AND TERMINATION

1. ELIGIBILITY. All employees, as determined by the Plan Sponsor, are eligible to enroll in the Plan. Employees must enroll themselves and any eligible dependents within 31 days of the date they first become eligible. The employee must enroll a newly acquired dependent (such as a new spouse) within 31 days of when the new dependent is first acquired. There may be additional situations when the employee is eligible to enroll after the first 31 days of eligibility. If there are any questions, contact the Plan Sponsor and see "**LATE ENROLLMENT**" below. All Eligible Employees hired directly from another Unity Point facility will be eligible to become covered under the Plan on their date of hire at Progressive Health Systems, Inc. or a Participating Employer if they were covered under a UnityPoint health plan as an active employee on their last day of work at the UnityPoint facility. All Eligible Employees hired directly from another UnityPoint facility will become covered under the Plan on the day following their last day of coverage as an active employee under the UnityPoint health plan or their date of hire at the Employer, whichever is later.

2. EFFECTIVE DATE. The employee and any dependent's effective date is determined by the Plan Sponsor.

An employee must be actively at work on the initial effective date of coverage or coverage for the employee and dependents will be delayed until the date the employee returns to work. The effective date of coverage shall not be delayed if the employee is not actively at work due to the employee's health status, medical condition, or disability.

For purposes of this provision, "actively at work" is the time period in which an employee is customarily performing all the regular duties of his/her occupation at the usual place of employment or business, or at some location to which that employment requires travel. An employee is considered actively at work for the time period absent from work solely by reason of vacation or holiday, if the employee was actively at work on the last preceding regular workday.

3. LATE ENROLLMENT. If you are a late enrollee, you may only enroll yourself and any eligible dependents during the Employer's annual open enrollment or if you or your dependents have met the criteria under "**SPECIAL ENROLLMENT PERIOD**" below.

4. SPECIAL ENROLLMENT PERIOD. An employee who is eligible, but not enrolled for coverage under the Plan, or a dependent of such employee if the dependent is eligible but not enrolled for coverage under the Plan, may enroll for coverage under the terms of the Plan if all of the following conditions are met:

a. the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;
b. the employee stated in writing at the time of initial eligibility that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the Plan Sponsor required such a statement at such time and provided the employee with notice of such requirement and the consequences of such requirement at such time;
c. the employee's or dependent's coverage described in a. above was:
    (1) under a COBRA continuation provision and the coverage under such provision was exhausted; or
    (2) not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including: as a result of legal separation; divorce; death; termination of employment; cessation of dependent status; reduction in the number of hours of employment; a situation in which the individual incurs a claim that would meet or exceed a lifetime limit on all benefits; a situation in which coverage is no longer offered to a class of similarly situated individuals that includes the individual; a situation in which an individual loses coverage through a health maintenance organization or other arrangement because that individual no longer

resides, lives or works in the health maintenance organization's service area or a situation in which the individual's benefit option is terminated) or employer contributions toward such coverage were terminated; and

d. the employee requested such enrollment not later than 31 days after the date of exhaustion of coverage described in c. (1) above, or one of the events listed in c. (2) above.

Dependent beneficiaries may enroll if: (a) a group health plan makes coverage available with respect to a dependent of an employee; (b) the employee is covered under the Plan (or has met any waiting period applicable to becoming a participant under the Plan and is eligible to be enrolled under the Plan but for a failure to enroll during a previous enrollment period); and (c) a person becomes a dependent of the employee through marriage, birth, or adoption or placement for adoption. The Plan shall provide for a dependent Special Enrollment Period during which the person (or, if not otherwise enrolled, the employee) may be enrolled under the Plan as a dependent of the employee and in the case of the birth or adoption of a child, the eligible dependents of the employee may be enrolled as a dependent of the employee if such eligible dependents are otherwise eligible for coverage. A dependent Special Enrollment Period shall be a period of not less than 31 days and shall begin on the later of:

a. the date dependent coverage is made available; or
b. the date of the marriage, birth, or adoption or placement for adoption described in (c) in the paragraph above.

If an individual seeks to enroll a dependent during the first 31 days of such a dependent Special Enrollment Period, the coverage of the dependent shall become effective:

a. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
b. in the case of a dependent's birth, as of the date of such birth; or
c. in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

5. SPECIAL RULES RELATING TO MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM ("CHIP"). In general – an employee who is eligible but not enrolled for coverage under the terms of the Plan (or a dependent of such an employee if the dependent is eligible but not enrolled for coverage under such terms) may enroll for coverage under the terms of the Plan if either of the following conditions is met:

a. Termination of Medicaid or CHIP Coverage – the employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a state child health plan under title XXI of such Act and coverage of the employee or dependent under such plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the Plan not later than 60 days after the date; or
b. Eligibility for Employment Assistance under Medicaid or CHIP – the employee or dependent becomes eligible for assistance, with respect to coverage under the Plan, under such Medicaid plan or state child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the Plan not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

6. ENROLLMENT OF NEWBORN OR NEWLY ADOPTED CHILDREN. Newborn infants and a newly adopted child may be covered if notice is received by the Plan within 60 days. However, the Plan must receive required payments, if any, from the date of eligibility for a newborn infant and a newly adopted child, before benefits will be paid. You must notify the Plan immediately of any change in eligibility of an enrolled dependent.

7. CHANGES IN BENEFITS. Any change in benefits is subject to the Plan Sponsor's approval. If a change in benefits is requested by the Plan Sponsor it is effective on the date they agree to. Any change in benefits required by law becomes effective according to applicable law.

8. TERMINATION. A Covered Person's coverage under the Plan terminates on the earliest to occur of the following events:

a. The contribution for coverage under the Plan is not made by the due date.

b. When a Covered Employee ceases to be eligible under the terms of this Plan, coverage for the employee and all Covered Dependents terminates on the last day of the month in which the employee's eligibility ceases, unless group continuation coverage is elected as described in section VII.

c. When a Covered Dependent no longer meets this Plan's definition of eligible dependent, coverage for that dependent terminates on the last day of the month in which the dependent's eligibility ceases, unless group continuation is elected as described in section VII.

d. When the maximum period under the group continuation coverage described in section VII. expires for a Covered Person.

e. The date the Plan terminates.

f. In the event of misrepresentation or omission of a material fact by the Covered Person regarding eligibility, enrollment, other coverage, claims or other expenses, the Plan Sponsor has the right to rescind coverage under the Plan or disenroll the Covered Person.

To the extent that a termination would be considered a rescission under federal law under terms b. and c. above, the Plan Sponsor is required to give the Covered Person 30 days advance notice of termination.

F. ACCESS TO RECORDS AND CONFIDENTIALITY

The Plan Sponsor complies with applicable state and federal laws governing the confidentiality and use of protected health information and medical records. As part of this Summary Plan Description, the Plan Sponsor is authorized to have access to and use protected health information held by any health care provider who delivers health care services to you under this Summary Plan Description. The Plan Sponsor is also allowed to use your protected health information when necessary, for: certain health care operations including, but not limited to: claims processing, including claims made for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management; care coordination and utilization management, disease management, underwriting, premium rating, claims experience reporting, the evaluation of potential or actual claims against the Plan Sponsor, auditing and legal services, and other access and use without further authorization if permitted or required by another law.

In the event that protected health information is disclosed to the Plan Sponsor, the Plan Sponsor may only use or disclose such information as permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations promulgated thereunder and as amended including, certain Plan administrative functions such as: claims review, subrogation, quality assurance, auditing, monitoring and management of carve out plans. Information may only be disclosed to the Plan Sponsor upon receipt, by the Plan, of a certification from the Plan Sponsor to the amendment of the Plan documents and that your Plan Sponsor agrees to:

- Not use or further disclose information except as listed above or as required or permitted by law;
- Ensure that any agents or subcontractors agree to the same restrictions and conditions that apply to your Employer or Plan Sponsor and that such agents and subcontractors agree to implement reasonable and appropriate security measures to protect electronic protected health information;
- Not use or disclose any information for employment – related actions or decisions;
- Not use or disclose any information in connection with any other employee benefit plan of your Employer or Plan Sponsor;
- Report to the Plan any security incident it becomes aware of and any use or disclosure of the information that is inconsistent with the uses or disclosures described above;

- Make information available to fulfill your right to access your protected health information;
- Make the information available for amendment or to incorporate applicable amendments;
- Make the information available in order to provide an accounting of disclosures;
- Make its internal practices, books and records relating to the use and disclosure of information received from the Plan available to the Department of Human Services to determine compliance with HIPAA;
- Return or destroy all protected health information received from the Plan, if feasible, when use or disclosure is no longer required. If return or destruction is not possible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- Ensure only certain classes of employees designated by your Employer are permitted access to your protected health information for Plan administration functions;
- Implement an effective mechanism for handling noncompliance by the employees designated access to your protected health information;
- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that is created, received, maintained or transmitted on behalf of the group health plan;
- Ensure adequate separation between the Plan and your Plan Sponsor is supported by reasonable and appropriate security measures.

II. DEFINITIONS OF TERMS USED

Admission. This is the medically necessary admission to an inpatient facility for the acute care of illness or injury.

Autism Spectrum Disorders. Pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder and Pervasive developmental disorders not otherwise specified.

Biosimilar Drugs. A prescription drug, approved by the Food and Drug Administration (FDA), that the FDA has determined is biosimilar to and interchangeable with a biological brand drug. Biosimilar drugs are not considered generic drugs and are not covered under the generic drug benefit.

Brand Drug. A prescription drug approved by the Food and Drug Administration (FDA), that is manufactured, sold, or licensed for sale under a trademark by the pharmaceutical company that originally researched and developed the drug. Brand drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand drug has expired. A few brand drugs may be covered at the generic drug benefit level if this is indicated on the formulary.

Calendar Year. This is the 12-month period beginning 12:01 A.M. Central Time, on January 1, and ending at midnight Central Time of the next following December 31.

Clinically Accepted Medical Services. These are techniques or services that have been determined to be effective for general use, based on risk and medical implications. Some clinically accepted medical services are approved only for limited use, under specific circumstances, as more fully described in this SPD.

Cosmetic Surgery. This is surgery to improve or change appearance (other than reconstructive surgery), which is not necessary to treat a related illness or injury.

Covered Dependent. This is the eligible dependent enrolled in the Plan.

Covered Employee. This is the eligible employee enrolled in the Plan.

Covered Person. This is the eligible and enrolled employee and each of his or her eligible and enrolled dependents covered for benefits under the Plan. When used in this SPD, "you" or "your" has the same meaning as Covered Person.

Covered Service. This is a specific medical or dental service or item, which is medically necessary or dentally necessary and covered by the Plan, as specifically described in this SPD.

Custodial Care. This is a supportive service focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to, bathing, dressing and feeding.

Dentally Necessary. This is care which is limited to diagnostic testing, treatment, and the use of dental equipment and appliances which, in the judgment of a dentist, is required to prevent deterioration of dental health, or to restore dental function. The Covered Person's general medical condition must permit the necessary procedure(s).

Dentist. A duly licensed doctor of dental surgery or dental medicine, lawfully performing a dental service in accordance with governmental licensing privileges and limitations.

Eligible Dependents. These are the persons shown below. Under the Plan, a person who is considered a Covered Employee is not qualified as an eligible dependent. A person who is no longer an eligible dependent (as defined below) on a Covered Employee's Plan may qualify for continuation of coverage within the group as provided in section VII. of this SPD.

Please note, for Covered Dependents who do not meet the definition of either a "qualifying child" or a "qualifying relative" under Internal Revenue Code Section 152, payments made by your Employer under this Plan for covered services may result in taxable income to the Covered Employee. Please consult with your Employer or tax advisor regarding your individual situation.

1. **Spouse.** This is a Covered Employee's current legal spouse. If more than one spouse is covered as an employee under the Plan, only one spouse shall be considered to have any eligible dependents.

2. **Child.** This is a Covered Employee's (a) natural or legally adopted child (effective from the date of adoption or the date placed for adoption, whichever is earlier); (b) child for whom the Covered Employee or the Covered Employee's spouse is the legal guardian; (c) foster child of the Covered Employee; (d) step-child of the Covered Employee (that is, the child of the Covered Employee's spouse); or (e) a child covered under a valid qualified medical child support order (as the term is defined under Section 609 of the Employee Retirement Income Security Act (ERISA) and its implementing regulations which is enforceable against a Covered Employee.* In each case the child must be either under 26 years of age or a disabled dependent, as described below. Coverage will terminate the end of the month in which the child turns age 26.

3. **Disabled Dependent.** This is a Covered Employee's dependent as referred to in 2. above, who is beyond the limiting age and is physically or mentally disabled, and dependent on the Covered Employee for the majority of his/her financial support. The disability must have come into existence prior to the attainment of the limiting age as described in 2. above. Disability does not include pregnancy. "Disabled" means incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder, or physical disability. The Covered Employee must give the Plan Sponsor a written request for coverage of a disabled dependent. The request must include written proof of disability and must be approved by the Plan Sponsor, in writing. The Plan Sponsor must receive the request within 31 days of the date an already enrolled dependent becomes eligible for coverage under this definition, or when adding a new disabled dependent eligible under this definition. The Plan Sponsor reserves the right to periodically review disability, provided that after the first two years, the Plan Sponsor will not review the disability more frequently than once every 12 months.

4. **Domestic Partner.** This is a Covered Employee's spousal equivalent as defined and determined by the Plan Sponsor. A domestic partner may not be an eligible dependent for all locations. Refer to the Plan's enrollment materials for further information regarding domestic partner eligibility.

* A description of the procedures governing qualified medical child support order determinations can be obtained by participants and beneficiaries, without charge, from the Plan Sponsor.

Emergency Accidental Dental Services. These are services required immediately, because of a dental accident.

Enrollment Date. This means the first day of coverage under the health benefit plan or the first day of the waiting period, if earlier.

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

Facility. This is a licensed medical center, clinic, hospital, skilled nursing facility or outpatient care facility, lawfully providing a medical service in accordance with applicable governmental licensing privileges and limitations.

Fiduciary. The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for benefits and to construe the terms of the Plan.

Formulary. This is a current list, which may be revised from time to time, of formulary prescription drugs, medications, equipment and supplies covered under the Plan as indicated in the Schedule of Payments which are covered at the highest benefit level. Some drugs may require prior authorization to be covered. The information on drugs that require prior authorization, are available by logging onto www.magellanrx.com or calling the Pharmacy Benefit Manager (PBM), Magellan Rx, at 800-424-0472.

Generic Drug. A prescription drug, approved by the Food and Drug Administration (FDA), that the FDA has determined is comparable to a brand drug product in dosage, form, strength, route of administration, quality, intended use and documented bioequivalence. Generally, generic drugs cost less than brand drugs. Some brand drugs may be covered at the generic drug benefit level if this is indicated on the formulary.

Habilitative Care. This is speech, physical or occupational therapy which is rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development. To be considered habilitative, measurable functional improvement and measurable progress must be made toward achieving functional goals, within a predictable period of time toward a Covered Person's maximum potential ability. The determination of whether such measurable progress has been made is within the sole discretion of the Plan, based on objective documentation.

Health Care Provider. This is any licensed non-physician (excluding naturopathic providers), including a chiropractor, lawfully performing a medical service in accordance with applicable governmental licensing privileges and limitations, who renders direct patient care to Covered Persons as covered under the Plan.

Hospice Program. This is a coordinated program of home-based, supportive and palliative care, for terminally ill patients and their families, to assist with the advanced stages of an incurable disease or condition. The services provided are comfort care and are not intended to cure the disease or medical condition, or to prolong life, in accordance with an approved home hospice treatment plan.

Hospital. This is a licensed facility, lawfully providing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an appropriate facility under the Plan. A hospital is not a nursing home, or convalescent facility.

Inpatient. This is a medically necessary confinement for acute care of illness or injury, other than in a hospital's outpatient department, where a charge for room and board is made by the hospital or skilled nursing facility. The Plan covers a semi-private room, unless a physician recommends that a private room is medically necessary. In the event a Covered Person chooses to receive care in a private room under circumstances in which it is not medically necessary, payment under the Plan toward the cost of the room shall be based on the average semi-private room rate in that facility.

Investigative. As determined by the Plan., a drug, device or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness or effect on health outcomes. The following categories of reliable evidence will be considered, none of which shall be determinative by itself:

1. Whether there is final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the U.S. Food and Drug Administration (FDA); if the drug or device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and
2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in the American Hospital Formulary Service as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility studying the same drug, device, medical treatment or procedure.

Late Enrollee. This is an eligible employee or dependent who enrolls under the Plan other than during:
1. the first period in which the individual is eligible to enroll under the Plan; or
2. the Employer's annual open enrollment period; or
3. a special enrollment period.

Maintenance Care. This is supportive services, including skilled or non-skilled nursing care, to assist you when your condition has not improved or has deteriorated significantly over a measurable period of time (generally a period of two months). Care may be determined to be maintenance care regardless of whether your condition requires skilled medical care or the use of medical equipment.

Medically Necessary/Medically Necessary Care. This is health care services that are appropriate in terms of type, frequency, level, setting and duration to your diagnosis or condition, diagnostic testing and preventive services. Medically necessary care, as determined by the Plan, must be:

1. Appropriate for the symptoms, diagnosis or treatment of your medical condition;
2. Consistent with evidence-based standards of medical practice where applicable;
3. Not primarily for your convenience or that of your family, your physician, or any other person; and
4. The most appropriate and cost-effective level of medical services or supplies that can be safely provided. When applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided in a lower level of care setting.

The fact that a physician, participating provider, or any other provider, has prescribed, ordered, recommended or approved a treatment, service or supply, or has informed you of its availability, does not in itself make it medically necessary.

Medicare. This is the federal government's health insurance program under Social Security Act Title XVIII, as amended. Medicare provides medical benefits to people who are 65 or older, or who are permanently disabled. The program has two parts: Part A and Part B. Part A generally covers the costs of hospitals and extended care facilities. Part B generally covers the costs of professional medical services. Both parts are subject to Medicare deductibles.

Mental Health Professional. This is a psychiatrist, psychologist, or mental health therapist licensed for independent practice, lawfully performing a mental or chemical health service in accordance with governmental licensing privileges and limitations, who renders mental or chemical health services to Covered Persons as covered under the Plan. For inpatient services, these mental health professionals must be working under the order of a physician.

Non-Preferred Brand Drug. Non-Preferred Brand medications are defined by the Pharmacy Benefit Manager (PBM). This is a prescription drug, approved by the Food and Drug Administration (FDA), that is not on the formulary, is medically necessary and is not investigative or otherwise excluded under this Plan.

Outpatient. This is medically necessary diagnosis, treatment, services or supplies rendered by a hospital's outpatient department, or a licensed surgical center and other ambulatory facility (other than in a physician's office).

Period of Confinement. This is (1) one continuous hospitalization, or (2) a series of hospitalizations or skilled nursing facility stays, or periods of time when the Covered Person is receiving home health services, for the same medical condition in which the end of one is separated from the beginning of the next by less than 90 days. For the purpose of this definition, "same condition" means illness or injury related to former illness or injury in that it is either within the same ascertainable diagnosis or set of diagnoses, or within the scope of complications or related conditions.

Physician. This is a licensed medical doctor, or doctor of osteopathy, lawfully performing a medical service, in accordance with governmental licensing privileges and limitations who renders medical or surgical care to Covered Persons as covered under the Plan.

Preferred Brand . Preferred Brand medications are defined by the Pharmacy Benefit Manager (PBM).

Preventative Services. Preventive Services means items or services with a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force found at: https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations,

Prescription Drug. This is any medical substance for the prevention, diagnosis or treatment of injury, disease or illness approved and/or regulated by the U.S. Food and Drug Administration (FDA). It must (1) bear the legend: "Caution: federal law prohibits dispensing without a prescription" or "Rx Only"; and (2) be dispensed only by authorized prescription of any physician or legally authorized health care provider under applicable state law.

Reconstructive Surgery. This is limited to reconstructive surgery, incidental to or following surgery, resulting from injury or illness of the involved part, or to correct a congenital disease or anomaly resulting in functional defect in a dependent child. A functional defect is one that interferes with a Covered Person's ability to perform activities of daily living.

Rehabilitative Care. This is a restorative service, which is provided for the purpose of obtaining significant functional improvement, within a predictable period of time, (generally within a period of two months) toward a patient's maximum potential ability to perform functional daily living activities.

Skilled Nursing Facility. This is a licensed skilled nursing facility, lawfully performing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an appropriate facility by the Plan, to render inpatient post-acute hospital and rehabilitative care and services to Covered Persons, whose condition requires skilled nursing facility care. It does not include facilities which primarily provide treatment of mental or chemical health.

Specialty Drug List. Specialty medications are defined by the Pharmacy Benefit Manager (PBM) which are typically bio-pharmaceuticals. The purpose of a specialty drug list is to facilitate enhanced monitoring of complex therapies used to treat specific conditions. The specialty drug list is available by logging onto www.magellanrx.com or calling the Pharmacy Benefit Manager (PBM), Magellan Rx, at 800-424-0472.

Virtual Care . Virtual Care provides telehealth (phone and video) consultations for routine conditions such as allergies, cough, flu symptoms, sore throats, and ear or sinus infections.

Waiting Period. This is the period of time that an individual must wait before being eligible for coverage under the Plan.

III. DESCRIPTION OF COVERED SERVICES

The Plan covers the services described below and on the Schedule of Payments. The Schedule of Payments describes the level of payment that applies for each of the covered services. To be covered under this section, the medical or dental services or items described below must be medically necessary or dentally necessary.

Coverage is subject to the exclusions, limitations, and other conditions of this Plan Document/SPD.

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the plan. In determining whether an expense is a covered service or supply under this plan, The plan may take into consideration:

- Any clinical coverage guidelines or medical policy as posted for The Plan on the Third Party Administrator's website;
- Medical peer reviews and recommendations provided by nationally recognized public and private organizations that review the medical effectiveness of health care services and technology;

A. AMBULANCE AND MEDICAL TRANSPORTATION

The Plan covers certain ambulance and medical transportation for medical emergencies and medically necessary, non-emergency medical transportation if it meets medical coverage criteria.

B. AUTISM SPECTRUM DISORDERS

Diagnosis and Treatment of Autism Spectrum Disorders including the following care when prescribed, provided or ordered for an Participant diagnosed with an Autism Spectrum Disorder by (a) a Physician or a Psychologist who has determined that such care is Medically Necessary, or (b) a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorders and when such care is determined to be Medically Necessary and ordered by a Physician or a Psychologist:

- Psychiatric care, including diagnostic services;
- Psychological assessments and treatments;

C. BEHAVIORAL HEALTH SERVICES

Mental Health and Chemical Health benefits are included in this Plan. Precedence is the administrator of these benefits and claims are paid by GPS.

Prior Authorization Requirements: Inpatient services, day treatment and intensive outpatient services, partial hospitalization services, opiate replacement therapy and psychotherapy and nursing services provided in the home require prior authorization. The prior authorization should be requested as soon as it is scheduled, but no later than the day of admission. In the event of a behavioral health emergency, you should contact Precedence for a hospital utilization management review within two business days of the admission. If prior authorization is not made, services will not be covered. Provider office visits do not require prior authorization requirements.

To request prior authorization, please contact Precedence at: 1-800-361-1492.

1. Mental Health Services

The Plan covers services for mental health diagnoses as described in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM 5) (most recent edition) that lead to significant disruption of function in the Covered Person's life.

a. **Outpatient Services.** The Plan covers medically necessary outpatient professional mental health services for evaluation, crisis intervention, and treatment of mental health disorders.

A comprehensive diagnostic assessment will be made of each patient as the basis for a determination by a mental health professional, concerning the appropriate treatment and the extent of services required.

Outpatient services covered by the Plan for a diagnosed mental health condition include the following:

(1) Individual, group, family, and multi-family therapy;
(2) Medication management provided by a physician, certified nurse practitioner, or physician's assistant;
(3) Psychological testing services for the purposes of determining the differential diagnoses and treatment planning for patients currently receiving behavioral health services;
(4) Day treatment and intensive outpatient services in a licensed program;
(5) Partial hospitalization services in a licensed hospital or community mental health center;
(6) Psychotherapy and nursing services provided in the home if authorized by Precedence; and
(7) Treatment for gender dysphoria that meets medical coverage criteria.

b. **Inpatient Services.** The Plan covers medically necessary inpatient services in a hospital and professional services for treatment of mental health disorders. Medical stabilization is covered under inpatient hospital services in the "Hospital and Skilled Nursing Facility Services" section.

2. Chemical Health Services

The Plan covers medically necessary services for assessments by a licensed alcohol and drug counselor and treatment of substance-related disorders as defined in the latest edition of the DSM 5.

a. **Outpatient Services including day treatment and intensive outpatient services.** The Plan covers medically necessary outpatient professional services for diagnosis and treatment of chemical dependency. Chemical dependency treatment services must be provided by a program licensed by the local Health and Human Services Department.

Outpatient services covered by the Plan for a diagnosed chemical dependency condition include the following:

(1) Individual, group, family, and multi-family therapy provided in an office setting;
(2) Opiate replacement therapy including methadone and buprenorphine treatment; and
(3) Day treatment and intensive outpatient services in a licensed program.

b. **Inpatient Services.** The Plan covers medically necessary inpatient services in a hospital or licensed chemical health treatment center.

The Plan covers services provided in a hospital that is licensed by the local state and accredited by Medicare.

Detoxification Services. The Plan covers detoxification services in a hospital or community detoxification facility if it is licensed by the local Health and Human Services Department.

Covered services are based on established level of care criteria. These level of care criteria are available by calling Precedence at: 1-800-361-1492.

Appeals and Complaints: See section VIII.D of this SPD for information regarding the appeal process through Precedence.

D. CHIROPRACTIC SERVICES

The Plan covers nonsurgical treatment of ailments related to the musculoskeletal system, such as manipulations or related procedures to treat musculoskeletal injury or disease.

Massage therapy which is performed in conjunction with other treatment/modalities by a chiropractor and is part of a prescribed treatment plan and is not billed separately is covered.

E. CLINICAL TRIALS

The Plan covers certain routine services if you participate in 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 as defined in the Affordable Care Act. The Plan covers routine patient costs for services that would be eligible under this Plan if the service were provided outside a clinical trial.

F. DENTAL SERVICES

1. Accidental Dental Services within the Network and Emergency Accidental Dental Services outside the Network . The Plan covers dentally necessary services to treat and restore damage done to sound, natural, unrestored teeth as a result of an accidental injury. Coverage is for damage caused by external trauma to face and mouth only, not for cracked or broken teeth which result from biting or chewing. The Plan covers restorations, root canals, crowns and replacement of teeth lost that are directly related to the accident in which the Covered Person was involved. The Plan covers initial exams, x-rays, and palliative treatment including extractions, and other oral surgical procedures directly related to the accident. Subsequent treatment must be completed within 12 months of the date of the injury and must be related to the accident. The Plan does not cover restoration and replacement of teeth that are not "sound and natural" at the time of the accident.

Full mouth rehabilitation to correct occlusion (bite) and malocclusion (misaligned teeth not due to the accident) are not covered.

When an implant-supported dental prosthetic treatment is pursued, the accidental dental benefit will be applied to the prosthetic procedure. Benefits are limited to the amount that would be paid toward the placement of a removable dental prosthetic appliance that could be used in the absence of implant treatment.

2. Medical Referral Dental Services.

a. **Medically Necessary Outpatient Dental Services.** The Plan covers certain medically necessary outpatient dental services. Coverage is limited to dental services required for treatment of an underlying medical condition, e.g., removal of teeth to complete radiation treatment for cancer of the jaw, cysts and lesions.

b. **Medically Necessary Hospitalization and Anesthesia for Dental Care.** The Plan covers certain medically necessary hospitalization and anesthesia for dental care. This is limited to charges incurred by a Covered Person who: (1) is a child under age five; (2) is severely disabled; (3) has a medical condition, and requires hospitalization or general anesthesia for dental care treatment; (4) is a child between age five and 13 and care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful; or (5) when extensive amounts of restorative care, exceeding four appointments, are required. Coverage is limited to facility and anesthesia charges. Anesthesia is covered in a hospital or a dental office. Oral surgeon/dentist professional fees are not covered. The following are examples, though not all-inclusive, of medical conditions which may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Except as listed above, hospitalization required due to the behavior of the Covered Person or due to the extent of the dental procedure is not covered.

c. **Medical Complications of Dental Care.** The Plan covers certain medical complications of dental care. Treatment must be medically necessary care and related to significant medical complications of non-covered dental care, including complications of the head, neck, or substructures.

3. **Oral Surgery.** The Plan covers certain oral surgery. Coverage is limited to treatment of medical conditions requiring oral surgery, such as treatment of oral neoplasm, non-dental cysts, fracture of the jaws and trauma of the mouth and jaws.

4. **Orthognathic Surgery Benefit.** The Plan covers orthognathic surgery for the treatment of severe skeletal dysmorphia where a functional occlusion cannot be achieved through non-surgical treatment alone and where a demonstrable functional impairment exists. Functional impairments include but are not limited to significant impairment in chewing, breathing or swallowing. Associated dental or orthodontic services (pre or post operatively including surgical rapid palatal expansion) are not covered as a part of this benefit.

5. **Treatment of Cleft Lip and Cleft Palate.** The Plan covers certain treatment of cleft lip and cleft palate of a dependent child, to the limiting age in the definition of an "Eligible Dependent", including orthodontic treatment and oral surgery directly related to the cleft. Benefits for individuals up to age 26 for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. Dental services which are not necessary for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under the Plan is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same copayment, conditions and limitations as durable medical equipment.

G. DIAGNOSTIC IMAGING SERVICES

The Plan covers diagnostic imaging, when ordered by a provider and provided in a clinic or outpatient hospital facility.

Non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility.

H. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

The Plan covers equipment and services, as described below. Case Management Prior Authorization is Required.

1. The Plan covers durable medical equipment and services, prosthetics, orthotics and supplies, subject to the limitations below, including certain disposable supplies, enteral feedings, and the following diabetic supplies and equipment: glucose monitors, insulin pumps, syringes, blood and urine test strips and other diabetic supplies as deemed medically appropriate and necessary, for Covered Persons with gestational, Type I or Type II diabetes.

   Diabetic supplies and equipment are limited to certain models and brands.

   The Plan covers special dietary treatment for Phenylketonuria (PKU) and oral amino acid based elemental formula if it meets medical coverage criteria.

2. Coverage of durable medical equipment is limited by the following:

   a. Payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary.
   b. For prosthetic benefits, other than oral appliances for cleft lip and cleft palate, payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary and enables Covered Persons to conduct standard activities of daily living.

The Plan reserves the right to determine if an item will be approved for rental vs. purchase3.

Items which are not eligible for coverage include, but are not limited to:

a. Replacement or repair of any covered items, if the items are: (1) damaged or destroyed by misuse, abuse or carelessness; (2) lost; or (3) stolen.
b. Duplicate or similar items.
c. Labor and related charges for repair of any covered items which are more than the cost of replacement by a designated vendor.
d. Sales tax, mailing, delivery charges, service call charges.
e. Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation.
f. Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, hearing aids (implantable and external, including Osseo integrated or bone anchored), fitting of hearing aids, speech processors, receivers, communication boards, or computer or electronic assisted communication. This exclusion does not apply to cochlear implants, which are covered if Medically Necessary.as determined by the Plan. Case Management Prior Authorization is Required.
g. Household equipment which primarily has customary uses other than medical, such as, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds.
h. Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools, whirlpools and saunas.
i. Modifications to the structure of the home including, but not limited to, its wiring, plumbing or charges for installation of equipment.
j. Vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carriers.
k. Rental equipment while the Covered Person's owned equipment is being repaired, beyond one month rental of medically necessary equipment.
l. Other equipment and supplies, including but not limited to assistive devices, that the Plan determines are not eligible for coverage.

Durable medical equipment and supplies must be obtained from or repaired by designated vendors. Covered services and supplies are based on Medical Necessity and Case Management Prior Authorization.

I. EMERGENCY AND URGENTLY NEEDED CARE SERVICES

Urgently Needed Care. These are services to treat an unforeseen illness or injury, which are required in order to prevent a serious deterioration in the Covered Person's health, and which cannot be delayed until the next available clinic hours.

Emergency Care. These are services to treat: (1) the sudden, unexpected onset of illness or injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization; or (2) a condition requiring professional health services immediately necessary to preserve life or stabilize health.

When reviewing claims for coverage of emergency services, a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment will be taken into consideration.

The Plan **must be** notified within two working days of admission to an out-of-network hospital, or as soon as reasonably possible under the circumstances.

The Plan covers services for emergency care and urgently needed care if the services are otherwise eligible for coverage in this SPD.

Out-of-network coverage under this section stops when treatment for the condition no longer meets the definition of emergency care or urgently needed care, or when the Covered Person's condition permits him or her to receive care within the network.

J. GENETIC MOLECULAR TESTING

Genetic molecular testing (specific gene identification) and related counseling when both of the following requirements are met:

i. the insured is an appropriate candidate for a test under medically recognized standards (for example, family background, past diagnosis, etc.)
ii. the outcome of the test is expected to determine a covered course of treatment or prevention and is merely informational.

Case Management Prior Authorization is Required.

K. HEALTH EDUCATION

The Plan covers education for preventive services and education for the management of chronic health problems (such as diabetes).

L. HOME HEALTH SERVICES

The Plan covers skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy and other therapeutic services, non-routine prenatal and postnatal services, routine postnatal well child visits, as described in the medical coverage criteria, phototherapy services for newborns, home health aide services and other eligible home health services when rendered in the Covered Person's home, if the Covered Person is homebound (i.e., unable to leave home without considerable effort due to a medical condition). Lack of transportation does not constitute homebound status. For phototherapy services for newborns and high risk pre-natal services, supplies and equipment are included.

The Plan covers total parenteral nutrition/intravenous ("TPN/IV") therapy, equipment, supplies and drugs in connection with IV therapy. IV line care kits are covered under Durable Medical Equipment.

The Plan covers palliative care benefits. Palliative care includes symptom management, education and establishing goals for care. The requirement that the Covered Person is homebound will be waived for a limited number of home visits for palliative care (as shown in the Schedule of Payments), if you have a life-threatening, non-curable condition which has a prognosis of two years or less. Additional palliative care visits are eligible under the home health services benefit if you are homebound and meet all other requirements defined in this section.

You do not need to be homebound to receive total parenteral nutrition/intravenous ("TPN/IV") therapy.

Home health services are eligible and covered only when they are:

1. medically necessary; and
2. provided as rehabilitative or terminal care; and
3. ordered by a physician, and included in the written home care plan.

Home health services are not provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home. The Plan will not reimburse family members or residents in the Covered Person's home for the above services.

A service shall not be considered a skilled nursing service merely because it is performed by, or under the direct supervision of, a licensed nurse. Where a service (such as tracheotomy suctioning or ventilator monitoring or like services) can be safely and effectively performed by a non-medical person (or self-administered), without the direct supervision of a licensed nurse, the service shall not be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of so-called "blended" services (i.e., services which include skilled and non-skilled components) are covered under the Plan. Home Health Services require Case Management Prior Authorization.

M. HOSPICE SERVICES

Applicable Definitions:

Part-time. This is up to two hours of service per day; more than two hours per day is considered continuous care.

Continuous Care. This is from two to 12 hours of service per day provided by a registered nurse, licensed practical nurse, or home health aide, during a period of crisis in order to maintain a terminally ill patient at home.

Appropriate Facility. This is a nursing home, hospice residence or other inpatient facility.

Custodial Care Related to Hospice Services. This means providing assistance in the activities of daily living and the care needed by a terminally ill patient which can be provided by a primary caregiver (i.e., family member or friend) who is responsible for the patient's home care.

1. **Hospice Program.** The Plan covers the services described below for Covered Persons who are terminally ill patients and accepted as hospice program participants. Covered Persons must meet the eligibility requirements of the program, and elect to receive services through the home hospice program. The services will be provided in the patient's home, with inpatient care available when medically necessary as described below. Covered Persons who elect to receive hospice services do so in lieu of curative treatment for their terminal illness for the period they are enrolled in the home hospice program. Case Management Prior Authorization is required.

    a. Eligibility: In order to be eligible to be enrolled in the home hospice program, a Covered Person must: (1) be a terminally ill patient (prognosis of six months or less); (2) have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than treatment attempting to cure the disease or condition); and (3) continue to meet the terminally ill prognosis as determined by the Plan over the course of care. . A Covered Person may withdraw from the home hospice program at any time.

    b. Eligible Services: Hospice services include the following services provided by Medicare-certified providers, if provided in accordance with an approved hospice treatment plan.
        (1) Inpatient Services: The Plan covers inpatient services in a hospice facility.
        (2) Home Health Services:
            (a) Part-time care provided in the Covered Person's home by an interdisciplinary hospice team (which may include a physician, nurse, social worker, and spiritual counselor) and medically necessary home health services are covered.
            (b) One or more periods of continuous care in the Covered Person's home or in a setting which provides day care for pain or symptom management, when medically necessary, will be covered.
        (3) Other Services:
            (a) Respite care is covered for care in the Covered Person's home or in an appropriate facility, to give the patient’s primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain a terminally ill patient at home.
            (b) Medically necessary medications for pain and symptom management.
            (c) Medically necessary semi-electric hospital beds and other durable medical equipment are covered.
            (d) Medically necessary emergency and non-emergency care is covered.

2. **What Is Not Covered.** The Plan does not cover the following services:
    a. financial or legal counseling services; or
    b. housekeeping or meal services in the patient's home; or
    c. custodial care related to hospice services, whether provided in the home or in a nursing home; or
    d. any service not specifically described as a covered service under this home hospice services section; or

e. any services provided by a member of the patient's family or resident in the Covered Person's home.

N. HOSPITAL AND SKILLED NURSING FACILITY SERVICES

1. Medical or Surgical Hospital Services

a. **Inpatient Hospital Services.** The Plan covers the following medical or surgical services, for the treatment of acute illness or injury, which require the level of care only provided in an acute care facility. These services must be authorized by a physician. Precertification is Required.

Inpatient hospital services include: room and board; the use of operating or maternity delivery rooms; intensive care facilities; newborn nursery facilities; general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, prescription drugs or other medications administered during treatment, blood and blood products (unless replaced) and blood derivatives, and other diagnostic or treatment related hospital services; physician and other professional medical and surgical services provided while in the hospital, including gender reassignment surgery that meets medical coverage criteria.

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

Services or items for personal convenience, such as television rental, are not covered.

b. **Outpatient Hospital, Ambulatory Care or Surgical Facility Services.** The Plan covers the following medical and surgical services, for diagnosis or treatment of illness or injury on an outpatient basis. These services must be authorized by a physician.

Outpatient services include: use of operating rooms, maternity delivery rooms or other outpatient departments, rooms or facilities; and the following outpatient services: general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, drugs administered during treatment, blood and blood products (unless replaced) and blood derivatives, and other diagnostic or treatment related outpatient services; physician and other professional medical and surgical services rendered while an outpatient, including gender reassignment surgery that meets medical coverage criteria.

Non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility.

To see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see the benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy in the Schedule of Payments.

2. Skilled Nursing Facility Care.

The Plan covers room and board, daily skilled nursing and related ancillary services for post-acute treatment and rehabilitative care of illness or injury, following a hospital confinement that meets medical coverage criteria. Case Management Prior Authorization is Required.

O. LABORATORY SERVICES

The Plan covers laboratory tests when ordered by a provider and provided in a clinic or outpatient hospital facility.

P. MASTECTOMY RECONSTRUCTION BENEFIT

The Plan covers reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce symmetrical appearance, and prostheses and treatment for physical complications during all stages of mastectomy, including lymphedemas.

Q. OFFICE VISITS FOR ILLNESS OR INJURY

The Plan covers the following when medically necessary: professional medical and surgical services and related supplies, including biofeedback, of physicians and other health care providers, and blood and blood products (unless replaced) and blood derivatives.

The Plan also covers diagnosis and treatment of illness or injury to the eyes. Where contact or eyeglass lenses are prescribed as medically necessary for the post-operative treatment of cataracts or for the treatment of aphakia or keratoconus, the initial evaluation, lenses and fitting are covered under the Plan. Covered Persons must pay for lens replacement beyond the initial pair.

R. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

The Plan covers the following physical therapy, occupational therapy and speech therapy services:

1. Rehabilitative care to correct the effects of illness or injury.
2. Habilitative care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development.

Massage therapy which is performed in conjunction with other treatment/modalities by a physical or occupational therapist and is part of a prescribed treatment plan and is not billed separately is covered. Case Management Prior Authorization is Required.

S. PRESCRIPTION DRUG SERVICES

The Plan covers prescription drugs and medications, which can be self-administered or are administered in a physician's office. Case Management Prior Authorization is Required.

T. PREVENTIVE SERVICES

The Plan covers the following Preventive Services:

1. Routine health exams and periodic health assessments. A physician or health care provider will counsel Covered Persons as to how often health assessments are needed based on the age, sex and health status of the Covered Person. This includes counseling for tobacco cessation.
2. Child health supervision services, including pediatric preventive services, routine immunizations, developmental assessments and laboratory services appropriate to the age of the child.
3. Routine prenatal care and exams to include visit-specific screening tests, education and counseling.
4. Routine postnatal care and exams to include health exams, assessments, education and counseling relating to the period immediately after childbirth.
5. Routine screening procedures for cancer.
6. Routine eye and hearing exams.
7. Adult immunizations.
8. Women's preventive health services; including mammograms, screenings for cervical cancer; breast pumps; human papillomavirus (HPV) testing; counseling for sexually transmitted

infections; counseling and screening for human immunodeficiency virus (HIV); and FDA approved contraceptive methods, sterilization procedures, education and counseling.

9. Obesity screening and counseling is covered for all ages during a routine preventive care exam. If you are age 18 or older and have a body mass index of 30 or more, intensive obesity management is covered to help you lose weight. Your primary care physician can coordinate the services.

Preventative Services are items or services with a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force found at: https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations that must be covered at 100%.

U. TRANSPLANT SERVICES

Autologous. This is when the source of cells is from the individual's own marrow or stem cells.

Allogeneic. This is when the source of cells is from a related or unrelated donor's marrow or stem cells.

Autologous Bone Marrow Transplant. This is when the bone marrow is harvested from the individual and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is then reinfused (transplanted).

Allogeneic Bone Marrow Transplant. This is when the bone marrow is harvested from a donor and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is reinfused (transplanted).

Autologous/Allogeneic Stem Cell Support. This is a treatment process that includes stem cell harvest from either bone marrow or peripheral blood, tumor ablation with high-dose chemotherapy and/or radiation, stem cell reinfusion, and related care. Autologous/allogeneic bone marrow transplantation and high dose chemotherapy with peripheral stem cell rescue/support are considered to be autologous/allogeneic stem cell support.

Designated Transplant Center. This is any health care provider, group or association of health care providers designated by the Plan to provide Transplant Services, supplies or drugs for specified transplants for Covered Persons.

Transplant Services. This is transplantation (including retransplants) of the human organs or tissue listed below, including all related post-surgical treatment, follow-up care and drugs and multiple transplants for a related cause. Transplant Services do not include other organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, except surgical implantation of an FDA approved Ventricular Assist Device (VAD) or total artificial heart, functioning as a temporary bridge to heart transplantation.

What is Covered. The Plan covers eligible Transplant Services (as defined above) while you are a Covered Person. Transplants that will be considered for coverage are limited to the following:

1. Kidney transplants for end-stage disease.
2. Cornea transplants for end-stage disease.
3. Heart transplants for end-stage disease.
4. Lung transplants or heart/lung transplants for: (a) primary pulmonary hypertension; (b) Eisenmenger's syndrome; (c) end-stage pulmonary fibrosis; (d) alpha 1 antitrypsin disease; (e) cystic fibrosis; and (f) emphysema.
5. Liver transplants for: (a) biliary atresia in children; (b) primary biliary cirrhosis; (c) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis; (d) primary sclerosing cholangitis; (e) alcoholic cirrhosis; and (f) hepatocellular carcinoma.
6. Allogeneic bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (a) acute myelogenous leukemia; (b) acute lymphocytic leukemia; (c) chronic myelogenous leukemia; (d) severe combined immunodeficiency disease; (e) Wiskott-Aldrich

syndrome; (f) aplastic anemia; (g) sickle cell anemia; (h) non-relapsed or relapsed non-Hodgkin's lymphoma; (i) multiple myeloma; and (j) testicular cancer.

7. Autologous bone marrow transplants or peripheral stem cell support associated with high-dose chemotherapy for: (a) acute leukemias; (b) non-Hodgkin's lymphoma; (c) Hodgkin's disease; (d) Burkitt's lymphoma; (e) neuroblastoma; (f) multiple myeloma; (g) chronic myelogenous leukemia; and (h) non-relapsed non-Hodgkin's lymphoma.
8. Pancreas transplants for simultaneous pancreas-kidney transplants for diabetes, pancreas after kidney, living related segmental simultaneous pancreas kidney transplantation and pancreas transplant alone.

To receive Network Benefits, charges for Transplant Services must be incurred at a designated transplant center or a Center of Excellence contracted by the Plan.

The transplant-related treatment provided, including the expenses incurred for directly related donor services, shall be subject to and in accordance with the provisions, limitations, maximums and other terms of this SPD.

Medical and hospital expenses of the donor are covered only when the recipient is a Covered Person and the transplant and directly related donor expenses have been prior authorized for coverage. Treatment of medical complications that may occur to the donor are not covered. Donors are not considered Covered Persons, and are therefore not eligible for the rights afforded to Covered Persons under this SPD.
The list of eligible Transplant Services and coverage determinations are based on established medical policies which are subject to periodic review and modification by the Plan. Case Management Prior Authorization is Required.

V. TRAVEL AND LODGING

Travel and lodging costs are covered only for out-of-region UnityPoint Health specialists and inpatient or outpatient facility care when care is not available from a UnityPoint specialist or at a facility within 60 miles of the Covered Person's home.

Travel and lodging reimbursement guidelines: If traveling between 60-180 miles (one way) for services, you will receive reimbursement for mileage only. If traveling beyond 180 miles (one way) you will receive reimbursement for mileage and lodging (up to a maximum benefit of $150 per night). Travel and lodging is limited to a maximum benefit of $1,500 per trip. Examples of allowed travel and lodging expenses include hotels, motels, cars, planes, trains, and RVs.

For information on how to be reimbursed for travel and lodging costs, call the Member Services at 888-301-0747.

W. WEIGHT LOSS SURGERY OR BARIATRIC SURGERY

Covered services are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) are available by logging onto groupplansolutions.com or by calling Member Services at 888-301-0747. Case Management Prior Authorization is Required.

IV. SERVICES NOT COVERED

In addition to any other benefit exclusions, limitations or terms specified in this Plan Document/SPD, the Plan will not cover charges incurred for any of the following services, except as specifically described in this Plan Document/SPD:

1. Treatment, procedures, services or drugs which are not medically necessary and/or which are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the Covered Person, including skills training.
2. Treatment, procedures or services which are not provided by a network provider, except for emergency services as described in this SPD.

3. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative, or otherwise not clinically accepted medical services. The Plan considers vagus nerve stimulator treatment for the treatment of depression and Quantitative Electroencephalogram treatment for the treatment of behavioral health conditions to be investigative and does not cover these services. The Plan considers the following transplants to be investigative and does not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in this SPD. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
4. Rest and respite services and custodial care, except as specified under the Hospice benefit. This includes all services, medical equipment and drugs provided for such care.
5. Room and board and care provided in halfway houses, extended care facilities, or comparable facilities, and residential treatment services.
6. Foster care, adult foster care and any type of family child care provided or arranged by the local state or county.
7. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies.
8. Services from non-medically licensed facilities or providers and services outside the scope of practice or license of the individual or facility providing the service.
9. Cosmetic surgery, cosmetic services and treatments primarily for the improvement of the Covered Person's appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures, scar revision and port wine stain removal. This exclusion does not apply to services for reconstructive surgery.
10. Commercial weight loss programs and exercise programs. Weight loss/bariatric surgery is only covered if it is performed by a designated network physician.
11. Dental treatment, procedures or services not listed in this SPD.
12. Vocational rehabilitation, recreational or educational therapy.
13. Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary, such as custody evaluations, vocational assessments, reports to the court, court ordered treatment, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations, and adoption studies.
14. Reversal of sterilization; assisted reproduction, including, but not limited to gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI) and/or in-vitro fertilization (IVF), and all charges associated with such procedures; diagnosis and treatment of infertility, including drugs for the treatment of infertility; artificial insemination; and sperm, ova or embryo acquisition, retrieval or storage.
15. Services related to the establishment of surrogate pregnancy and fees for a surrogate are not covered. Pregnancy and maternity services are covered for a Covered Person under this Plan.
16. Acupuncture.
17. Care that is not rehabilitative in nature and medically necessary for the diagnosis and/or treatment of acute neuromusculoskeletal conditions.
18. Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and their fitting, measurement and adjustment, and hearing aids (implantable and external, including osseo integrated or bone anchored) and their fitting. This exclusion does not apply to cochlear implants, which are covered if Medically Necessary as determined by the Plan. Case Management Prior Authorization is Required.
19. Medical Food. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as specified in this SPD. This exclusion does not apply to oral amino acid based elemental formula or other items if they meet medical coverage criteria.
20. Charges for sales tax.
21. Services provided by a family member of the Covered Person, or a resident in the Covered Person's home.
22. Religious counseling, marital/relationship counseling and sex therapy.
23. Private duty nursing services.
24. Services that are rendered to a Covered Person, who also has other primary insurance coverage for those services and who does not provide the Plan the necessary information to pursue coordination of benefits, as required under the Plan.

25. The portion of a billed charge for an otherwise covered service by a provider, which is in excess of the usual and customary charges, or which is either a duplicate charge for a service or charges for a duplicate service.
26. Charges for services (a) for which a charge would not have been made in the absence of insurance or medical plan coverage, or (b) which the Covered Person is not legally obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the Covered Person.
27. Travel and lodging incidental to travel, regardless if it is recommended by a physician and any travel billed by a provider. This exclusion does not apply to approved travel and lodging costs when related to out of region UnityPoint Health specialists and inpatient or outpatient facility care when care is not available from a UnityPoint specialist or at a facility within 60 miles of the Covered Person's home.
28. Health club memberships.
29. Massage therapy for the purpose of a Covered Person's comfort or convenience.
30. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
31. Autopsies.
32. Charges incurred for transplants, Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) received at facilities which are not designated facilities, or charges incurred for weight loss services provided by a physician who is not a designated physician.
33. Accident related dental services if treatment is (1) provided to teeth which are not sound and natural, (2) to teeth which have been restored, (3) received beyond the initial treatment or restoration, or (4) received beyond 12 months from the date of injury.
34. Nonprescription (over-the-counter) drugs or medications, unless listed on the formulary and prescribed by a physician or legally authorized health care provider under applicable state law, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the Covered Person obtains a prescription for the item.
35. Services for certain disorders related to early childhood, such as academic underachievement disorder.
36. Services for communication disorders, such as stuttering and stammering.
37. Services for impulse control disorders, such as pathological gambling.
38. Services for nonpervasive developmental and learning disorders.
39. Professional services associated with substance abuse intervention. A "substance abuse intervention" is a gathering of family and/or friends to encourage a person covered under this SPD to seek substance abuse treatment.
40. Charges for elective home births.
41. Drugs for the treatment of sexual dysfunction.
42. Hair prosthesis (wigs).
43. Services provided by naturopathic providers.
44. Oral surgery to remove wisdom teeth.
45. All services or supplies for treatment of temporomandibular disorder (TMD/TMJ), myofacial pain syndrome, or craniomandibular dysfunction (CMD).
46. Treatment, procedures, or services or drugs which are provided when you are not covered under this Plan.
47. Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
48. Non-medical administrative fees and charges, including but not limited to, medical record preparation charges, appointment cancellation fees, after hours appointment charges, and interest charges.
49. Elective abortions, except in situations where the life of the mother would be endangered if the fetus is carried to full term or when the pregnancy is the result of an act of rape or incest.
50. Medical cannabis.
51. Any treatment that does not meet the clinical coverage guidelines or medical coverage policies as posted on the Third Party Administrator's website.
52. Never Events which means any occurrence on a United States list of inexcusable outcomes in a health care setting compiled by the National Quality Forum. They are defined as "adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability."

V. DISPUTES AND COMPLAINTS

A. DETERMINATION OF COVERAGE

Eligible services are covered only when medically necessary for the proper treatment of a Covered Person.
Covered prescription drugs are based on requirements established by the Pharmacy Benefits Manager

In determining whether an expense is covered the Plan will consider:

- The definitions, provisions, limitations and exclusions in the plan document; and
- Clinical coverage guidelines and medical policies as posted on the public website of the Third Party Administrator; and
- Medical peer reviews and recommendations provided by nationally recognized public and private organizations which review the medical effectiveness of health care services and technology

If your claim for medical services was denied based on clinical coverage criteria, you or your provider can appeal the decision. Call Member Services for assistance.

B. COMPLAINTS

The Plan has a complaint procedure to resolve complaints and disputes. Complaints should be made in writing or orally. They may concern the provision of care by network providers, administrative actions, or claims related to the Plan. The complaint system seeks to resolve a dispute which arose during the time of your coverage, or application for coverage.

Complaints must be made to:
Group Plan Solutions Benefit Administration,
a division of Pekin Insurance
2505 Court Street
Pekin, IL 61558
Phone: 888-301-0747 (toll-free)
Fax: 855-545-7165

VI. CONDITIONS

A. RIGHTS OF REIMBURSEMENT AND SUBROGATION

If services are provided or paid for under the Plan to treat an injury or illness: (1) caused by the act or omission of another party; (2) covered by no fault insurance or other auto insurance or employers liability laws; (3) available or required to be furnished by or through national or state governments or their agencies; or (4) sustained on the property of a third party, the Plan Sponsor or its designee has the right to recover the reasonable value of services and payments made. This right shall be by reimbursement and subrogation. The right of reimbursement means you must repay the Plan Sponsor or its designee at the time you make any recovery. Recovery means all amounts received by you from any persons, organizations or insurers by way of settlement, judgment, award or otherwise on account of such injury or illness. The right of subrogation means that the Plan Sponsor or its designee may make claim in your name or the Plan Sponsor's name against any persons, organizations or insurers on account of such injury or illness. Attorneys' fees and expenses incurred by a Covered Person in connection with the recovery of monies from third parties may not be deducted from subrogation/reimbursement amounts, unless agreed to by the Plan Sponsor in its discretion.

In addition, the Plan will have a lien on any amounts payable by a third party or under an insurance policy or program, to the extent covered expenses are paid by the Plan Sponsor’s Medical Benefit Plan.

The rights of reimbursement and subrogation apply whether or not the Covered Person has been fully compensated for losses or damages by any recovery of payments, and the Plan Sponsor or its designee will be entitled to immediately collect the present value of subrogation rights from said payments.

If, after recovery of any payments, you receive services or incur expenses on account of such injury or illness, you may be required to pay for such services or expenses. The total of all reimbursement and payments will not exceed your recovery.

This right of reimbursement and subrogation applies to any type of recovery from any third party, including but not limited to recoveries from tortfeasors, underinsured motorist coverage, uninsured motorist coverage, medical payments coverage, other substitute coverage or any other right of recovery, whether based on tort, contract, equity or any other theory of recovery. The right of reimbursement is binding upon you, your legal representative, your heirs, next of kin and any trustee or legal representative of your heirs or next of kin in the event of your death. Any amounts you receive from such a recovery must be held in trust for the Plan's benefit to the extent of subrogation claims.

You agree to cooperate fully in every effort by the Plan Sponsor or its designee to enforce the rights of reimbursement and subrogation. You also agree that you will not do anything to interfere with those rights. You agree to promptly inform the Plan Sponsor in writing of any situation or circumstance which may allow the Plan Sponsor to invoke its rights under this section.

B. COORDINATION OF BENEFITS

You agree, as a Covered Person, to permit the Plan to coordinate payments under any other medical benefit plans as specified below, which cover you or your dependents. You also agree to provide any information or submit any claims to other medical benefit plans necessary for this purpose. If you fail to provide this information, your claim may be delayed or denied. You agree to authorize the Plans billing to other medical plans, for purposes of coordination of benefits.

Unless applicable law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under the Plan must provide any facts needed to pay the claim.

1. Applicability.

a. This Coordination of Benefits (COB) provision applies to the Plan when a Covered Employee or the Covered Employee's Covered Dependent has medical care coverage under more than one plan. "Plan" and "The Plan" are defined below.

b. If this Coordination of Benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of The Plan are determined before or after those of another plan. The benefits of The Plan:

(1) shall not be reduced when, under the order of benefit determination rules, benefits under The Plan are determined before another plan; but

(2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in paragraph 4. below.

2. Definitions.

a. **"Plan"** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

b. **"The Plan"** is the part of the Plan that provides benefits for medical care expenses.

c. **"Primary Plan/Secondary Plan"** The order of benefit determination rules state whether The Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When The Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.
When The Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.
When there are more than two plans covering the person, The Plan may be a Primary Plan as to one or more of the plans and may be a Secondary Plan as to a different plan or plans.

d. **"Allowable Expense"** is a necessary, reasonable and customary item of expense for medical care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.
The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.
When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.
When benefits are reduced under a primary plan because a Covered Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements.

e. **"Claim Determination Period"** is a calendar year. However, it does not include any part of a year during which a person has no coverage under The Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

3. Order of Benefit Determination Rules.

a. **General**. When there is a basis for a claim under The Plan and another plan, The Plan is a Secondary Plan which has its benefits determined after those of another plan, unless:
(1) the other plan has rules coordinating its benefits with those of The Plan; and
(2) both those rules and The Plan's rules, in subparagraph b. below, require that The Plan's benefits be determined before those of the other plan.

b. **Rules**. The order of benefits are determined using the first of the following rules which applies:
(1) Nondependent/Dependent. The benefits of the plan which cover the person as a Covered Person or subscriber (that is, other than as a dependent) are determined before those of the plan which cover the person as a dependent.
(2) Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph b. (3) below, when The Plan and another plan cover the same child as a dependent of different persons, called "parents":
(a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
(b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
(3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
(a) first, the plan of the parent with custody of the child;
(b) then, the plan of the spouse of the parent with the custody of the child; and
(c) finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the medical care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other

parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or calendar year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for medical care expenses of the child, the plans covering the child follow the order of benefit determination rules outlined in subparagraph b. (2).

(5) Active/Inactive Enrollee. The benefits of a plan which covers a person as a Covered Employee who is neither laid off nor retired (or as that Covered Employee's dependent) are determined before those of a plan which cover that person as a laid off or retired Covered Employee (or as that Covered Employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered a Covered Person or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. Effect on the Benefits of this Plan.

a. **When this Section Applies**. This paragraph 4. applies when, in accordance with paragraph 3. "Order of Benefit Determination Rules", The Plan is a Secondary Plan as to one or more other plans. In that event the benefits of The Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in b. immediately below.

b. **Reduction in the Plan's Benefits**. The benefits of The Plan will be reduced when the sum of:

(1) the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of The Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of The Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of The Plan.

c. **Benefit Reserve**. The Secondary Plan shall calculate its savings by subtracting the amount that it paid as a Secondary Plan from the amount it would have paid had it been primary "COB Savings". These COB Savings shall be recorded in the benefit reserve for the Covered Person and shall be used by the Secondary Plan to pay any allowable expenses, not otherwise paid, that are incurred by the Covered Person during the Claim Determination Period. As each claim is submitted, the Secondary Plan must:

(1) determine its obligation, pursuant to the contract;

(2) determine whether a benefit reserve has been recorded for the Covered Person; and

(3) determine whether there are any unpaid allowable expenses during that Claim Determination Period.

If there is a benefit reserve, the Secondary Plan shall use the Covered Person's recorded benefit reserve to pay up to 100% of the total incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero. A new benefit reserve must be created for each Claim Determination Period. (A Claim Determination Period is based on calendar year.)

5. Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts are needed. Consistent with applicable state and federal law, the Plan may get needed facts from or give them to any other organization or person, without your further approval or consent. Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under The Plan must give any facts the Plan needs to pay the claim.

6. **Facility of Payment**. A payment made under another plan may include an amount which should have been paid under The Plan. If it does, the Plan Sponsor may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under The Plan. The Plan Sponsor will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7. **Right of Recovery**. If the amount of the payments made by the Plan Sponsor is more than the amount that should have paid under this COB provision, the Plan may recover the excess from one or more of:
   a. the persons it has paid or for whom it has paid;
   b. insurance companies; or
   c. other organizations.

   The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

   The benefits provided by the Plan do not apply to injury or disease covered by no-fault insurance, employers liability laws (including workers' compensation), and care available or required to be furnished by or through national or state governments or their agencies including care to which a Covered Person is legally entitled and for which facilities are reasonably available for military service-connected conditions or disabilities. Subject to the Plan's rights in A. "Rights of Reimbursement and Subrogation" above, medically necessary services will be provided upon request and only expenses incurred for medical treatment otherwise covered by the Plan will be paid if the no-fault insurer, employer, or national or state government or its agencies refuse to pay said expenses. You must cooperate with the Plan's program to bill allowable no-fault and workers' compensation claims to the appropriate insurer(s).

C. MEDICARE AND THE PLAN

The provisions in this section apply to some, but not all, Covered Persons who are eligible for Medicare. They apply in situations where the federal Medicare Secondary Payer Program allows Medicare to be the primary payer of a Covered Person's medical care claims. Consult your Employer to determine whether or not Medicare is primary in your situation.

In general, Medicare is secondary payer for Medicare enrollees who: (1) are active employees and (2) are covered by Medicare because they have reached age 65 when there are 20 or more employees in the group. The Medicare secondary payer rules change from time to time and the most recent rule will be applied.

Medicare is the primary payer:

1. For Covered Persons with end stage renal disease, after the 30 month period following the earlier of (1) the month in which the Covered Person begins a regular course of renal dialysis, or (2) the first of the month in which the Covered Person became entitled to Medicare, if the Covered Person received a kidney transplant without first beginning dialysis. This is regardless of the size of the Employer.
2. For retirees who are age 65 or over.
3. For Covered Persons under age 65, who are covered by Medicare because of disability (other than end stage renal disease), when (1) the Employer employs fewer than 100 employees and the Covered Person or their spouse or parent has group health plan coverage due to current employment, or (2) the Covered Person or their spouse or parent has coverage not due to current employment, regardless of the number of employees of the Employer.

If Medicare is the primary payer, the benefits under the Plan are not intended to duplicate any benefits to which Covered Persons are, or would be, entitled under Medicare. All sums payable under Medicare for services provided pursuant to the Plan shall be payable to and retained by the Plan Sponsor. Each Covered Person shall complete and submit to the Plan such consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare for which Covered Persons are eligible.

If Medicare is the primary payer, the Plan also reserves the right to reduce benefits for any medical expenses covered under the Plan by the amount of any benefits available for such expenses under Medicare. This will be done before the benefits under the Plan are calculated. Charges for services used to satisfy a Covered Person's Medicare Part B deductible will be applied under the Plan in the order received by the Plan. Two or more charges for services received at the same time will be applied starting with the largest first.

If Medicare is the primary payer, the benefits under the Plan will only be reduced to the extent that the Covered Person has actually enrolled in Medicare.

The provisions of this section will apply to the maximum extent permitted by federal or state law. The Plan will not reduce the benefits due any Covered Person due to that Covered Person's eligibility for Medicare where federal law requires that the Plan determine the benefits for that Covered Person without regard to the benefits available under Medicare.

VII. CONTINUATION OF GROUP COVERAGE

As required by the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), if your eligibility for group coverage under the Plan ends because of one of the qualifying events shown below, you may be eligible to continue group coverage as shown below.

CONTINUATION OF GROUP COVERAGE

1. Qualifying Events. Coverage under the Plan may be continued by a Covered Employee, Covered Dependent spouse and other Covered Dependents, enrolled at the time coverage would otherwise end, or a child born to or placed for adoption with the Covered Employee during the period of continuation coverage, as a result of one of the following qualifying events:

a. Termination of employment (except for gross misconduct) of the Covered Employee, or reduction in hours resulting in a loss of group coverage.
b. Death of the Covered Employee.
c. Divorce or legal separation of the Covered Employee.
d. Loss of eligibility as a Covered Dependent child.
e. Initial enrollment of the Covered Employee for Medicare.
f. For a retired Covered Employee, spouse and other dependents, the bankruptcy filing by a former Employer, under Title XI, United States Code, on or after July 1, 1986.

2. Duration of Continuation Coverage. The maximum period coverage can be continued depends on the qualifying event. Continuation coverage may be terminated earlier as shown below. The maximum period of continuation coverage starts on the day of the qualifying event.

a. **Maximum period**

(1) **Termination and reduced hours.** The maximum period of continuation coverage is 18 months. If a second qualifying event, other than the Employer's bankruptcy, occurs during the 18 months, the maximum period of continuation coverage is 36 months.

(2) **Disabled Covered Employee, Covered Dependent spouse or Covered Dependent child.** If the Covered Employee, Covered Dependent spouse or other Covered Dependent is disabled under Title II or XVI of the Social Security Act, at the time of the termination of employment, or reduced hours of the Covered Employee, or within the first 60 days of continuation of coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the Plan Sponsor within 60 days of the date of determination of disability, and within the initial 18-month continuation period. If a second qualifying event (other than bankruptcy) occurs during the extended 29-month period, the maximum period of continuation coverage is 36 months.

(3) **Bankruptcy.** In the case of bankruptcy of a retired Covered Employee's former Employer, the maximum period of continuation coverage is until the death of the retired Covered Employee. In the case of the surviving spouse or dependent children of the retired Covered

Employee, the maximum period of continuation coverage is 36 months after the death of the retired Covered Employee.

(4) **Divorce or legal separation.** The maximum period of coverage for a former spouse or dependents who lose coverage due to divorce or legal separation is 36 months.

(5) **Death of Covered Employee.** The maximum period of coverage for a Covered Dependent surviving spouse and Covered Dependents who lose coverage due to the death of the Covered Employee is 36 months.

(6) **Other qualifying events.** The maximum period of continuation coverage for all other qualifying events is 36 months.

b. **Earlier Termination**

Coverage terminates before the end of the maximum period if any of the following occurs.

(1) **End of the Plan.** The Plan under which this coverage is offered to Covered Employees is terminated.

(2) **Failure to pay premium.** The person receiving continuation coverage does not make the monthly payment within 30 days of the due date.

(3) **Other group health coverage.** The person receiving continuation coverage becomes covered under any other group health type coverage, not containing an exclusion or limitation for any pre-existing condition of the person. If the other group health coverage contains a pre-existing condition limitation, continuation coverage is extended until the pre-existing limitation is satisfied or coverage is otherwise terminated. A person will not be subject to earlier termination of continuation coverage on account of coverage under another group plan that existed prior to that person's first day of continuation coverage.

(4) **Termination of extended coverage for disability.** In case a person receives extended (29-month) continuation coverage due to disability at the time of termination or reduced hours, the extended coverage terminates at the beginning of the month 30 days after a final determination that the person is no longer disabled.

(5) **Termination provisions of this Summary Plan Description.** The person's coverage is subject to termination under section I. of this Summary Plan Description.

(6) **Enrollment under Medicare.** The person receiving continuation coverage becomes entitled to and covered under Medicare Part A or B coverage. A person will not be subject to earlier termination of continuation coverage on account of coverage under Medicare that existed prior to that person's first day of continuation coverage.

3. Election of Continuation Coverage

a. You have 60 days to elect continuation of group coverage. The 60-day period begins on the date your group coverage would otherwise terminate due to a qualifying event or the date on which written notice of your right of continued group coverage is mailed, whichever is later.

b. If you wish to continue group coverage as shown above, you must apply in writing to your Employer (not the Third Party Administrator). You must also pay your first monthly payment within 45 days of the date you elected to continue group coverage. Thereafter, your monthly payments are due and payable at the beginning of each month for which coverage is to be continued.

c. You or your Covered Dependents must notify the Plan Sponsor within 60 days, when divorce, legal separation, a change in status resulting in a loss of eligibility as a dependent would end coverage or a second qualifying event occurs. The 60 day period begins on the date of the divorce, legal separation, change in dependent status or second qualifying event.

4. Procedures for Providing Notices Required Under This Continuation of Group Coverage Section

a. You must comply with the time limits for providing notices required in paragraph 3 (c) above.

b. Your notice must be in writing and contain at least the following information:

(1) The names of the Covered Employee and Covered Dependents;
(2) the qualifying event or disability; and
(3) the date on which the qualifying event (if any) occurred.

c. Your notice must be sent to:

Discovery Benefits
4321 20th Avenue Southwest
Fargo, ND 58103
Telephone: 1-866-451-3399

The Plan will comply with applicable federal law for a Covered Employee that is called to active military duty in the uniformed services.

VIII. FILING A CLAIM, CLAIMS PROCEDURES, APPEAL PROCEDURES

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

Health Claims

All claims and questions regarding health claims should be directed to the Third Party Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator, or the Claims Administrator, decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion, unless the Plan Administrator has delegated such fiduciary authority to the Claims Administrator. .

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

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

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

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

Benefits will be payable to a Plan Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered. Payment to a provider does not make the Provider the Participant's authorized representative for ERISA purposes or give the provider any standing under ERISA to bring a claim for benefits on behalf of the Participant. If a Participant wishes to appoint an authorized representative to handle his or her appeal of an Adverse Benefit Determination, the Participant must designate his or her Provider as an authorized representative in accordance with the Plan's procedures

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

- Pre-service Claims. A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

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

  If the Plan does not require the Participant to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

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

  - The Plan Administrator determines that the course of treatment should be reduced or terminated; or

  - The Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

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

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

When Health Claims Must Be Filed
Post-service health claims must be filed with the Third Party Administrator within 12 months of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

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

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

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

- Pre-service Urgent Care Claims:

    - If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

    - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim.

    - The Participant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:

        - The Plan's receipt of the specified information; or

        - The end of the period afforded the Participant to provide the information.

If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

- Pre-service Non-urgent Care Claims:

    - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

    - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

- Concurrent Claims:

    - Plan Notice of Reduction or Termination. If the Claims Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

    - Request by Participant Involving Urgent Care. If the Claims Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, as long as the Participant makes the request at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

    - Request by Participant Involving Non-urgent Care. If the Claims Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent

claim or a post-service claim).

- Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:
  - Notification to Participant 30 days
  - Notification of Adverse Benefit Determination on appeal 30 days

- Post-service Claims:
  - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Claims Administrator and the Participant.

- Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

- Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15- day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

Notification of an Adverse Benefit Determination

The Claims Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will contain the following information:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal and a statement

of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request;

- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes; and

- In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

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

- Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;

- Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

- For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of

the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

- That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and

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

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

Group Plan Solutions Benefit Administration,
a Division of Pekin Insurance
2505 Court Street
Pekin, IL 61558
Phone: 888-301-0747
Fax: 855-545-7165
Email: inquiry@groupplansolutions.com
Website: www.groupplansolutions.com

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

Group Plan Solutions Benefit Administration,
a Division of Pekin Insurance
2505 Court Street
Pekin, IL 61558
Phone: 888-301-0747
Fax: 855-545-7165
Email: inquiry@groupplansolutions.com
Website: www.groupplansolutions.com

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

- The name of the employee/Participant;

- The employee/Participant's social security number;

- The group name or identification number;

- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal**;

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

claim; and

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

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

Timing of Notification of Benefit Determination on Review

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

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances; but not later than 30 days after receipt of the appeal.

- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim; pre-service urgent, pre-service non-urgent or post-service.

- Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Manner and Content of Notification of Adverse Benefit Determination on Review

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

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be

provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and

- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

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

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

External Review Process

A. Scope

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

2. The Federal external review process applies only to:

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

B. Standard external review
Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

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

2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   (b) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the

claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

(c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and

(d) The claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

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

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

C. Expedited external review

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

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

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

4. Notice of final external review decision. The Plan's (or Third Party Administrator's) contract with the

assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

IX. NOTICES AND PROVISIONS

The Plan Sponsor and its delegates have the maximum discretionary authority permitted by law to interpret, construe and administer the Plan, to make determinations, including factual determinations, regarding Plan participation, enrollment and eligibility for benefits, to evaluate and determine the validity of benefit claims, to grant or deny benefits, and to resolve any and all claims and disputes regarding the rights and entitlements of individuals to participate in the Plan and to receive benefits and payments pursuant to the Plan.

The Plan Sponsor and its delegates have the authority to require participants and/or covered dependents to furnish them with such information as they deem necessary or appropriate for the proper administration of the Plan, including, for example, proof of eligibility. The Plan Sponsor also may adopt such rules and procedures as it deems desirable for the administration of the Plan.

Exhaustion of Administrative Remedies. All actions, interpretations and decisions of the Plan Sponsor and its delegates will be conclusive and binding on all persons and entities, and will be given the maximum possible deference permitted by law. If you have a claim for ERISA Plan benefits that is denied, in whole or in part, and you have exhausted the applicable appeal procedure under the ERISA Plan for every issue that you deem relevant with respect to your claim, or if you have a claim for ERISA Plan benefits that is ignored, you may file a lawsuit or other legal action in a state or federal court. However, any such lawsuit or other court action must be filed no later than ninety (90) days after the final claim denial, regardless of any state or federal statues establishing provisions relating to limitations on actions. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.

1. GENERAL PLAN PROVISIONS

No Guarantee of Employment. By adopting and maintaining the Plan, the Employer has not entered into any employment contract with any individual. Nothing in the official Plan documents, the benefit plan materials or any designated SPD materials, gives any individual the right to be employed by the Employer or any of its affiliates or to interfere with the Employer's or its affiliate's right to discharge any employee at any time. Your employment is always on an at-will basis.

No Transfer of Any Rights. No benefit, right or interest of any participant, dependent or beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities or other obligations of such person; except as (i) required under a Qualified Medical Child Support Order as described in Section 609 of ERISA, or (ii) where required under a state Medicaid law. Medical coverage benefits under the Plan may not be assigned, transferred or in any way made over to another party by a participant. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, garnish, execute or levy upon, or otherwise dispose of any right to benefits payable hereunder, shall be void. A direction to pay a provider does not cause the provider to be a Plan beneficiary and does not constitute not an assignment of any right under the Plan or of any legal or equitable right to institute any court proceeding or to request or receive plan documents under ERISA. The Plan prohibits any participant, dependent or beneficiary from assigning his or her right to bring a suit under ERISA to a physician or other health care providers who accept assignments of claims. Nothing contained in this SPD describing medical coverage shall be construed to make the Plan or UnityPoint or its affiliates liable to any third-party to whom a participant, dependent or beneficiary may be liable for medical care, treatment, or services.

No Vested Rights to Any Plan Benefits. You have no vested rights to any benefits under the Plan.

2. SPECIAL NOTICES

Women's Health and Cancer Rights Act of 1998. If you had, or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For Plan participants receiving mastectomy-related benefits, coverage will be provided in a manner determinate in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of the mastectomy, including lymphedemas.

The coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the Plan. Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Consult the applicable benefit plan materials or contact the Plan Administrator for more information.

Newborns' and Mothers' Health Protection Act of 1996. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, precertification may be required for a hospital stay of more than 48 (or 96 hours, as applicable) in connection with childbirth. The laws of your state related to hospital stays in connection with childbirth may differ from these federal requirements. Consult the applicable benefit plan materials for more information.

Special Rights under MHPA and MHPAEA. The Mental Health Parity Act ("*MHPA*") and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("*MHPAEA*") contain certain requirements for group health plans and health insurance issuers concerning certain mental health and substance use disorder benefits. Any benefit plan that is subject to these requirements will provide for applicable parity of any aggregate lifetime dollar limits and annual dollar limits with respect to any mental health and substance use disorder benefits that may be provided. In addition, each such benefit plan will provide for applicable parity between any medical and surgical benefits offered by the benefit plan, on the one hand, and any mental health and substance use disorder benefits, on the other, as to any financial requirements (such as deductibles, co-payments, co-insurance and out-of-pocket maximums) and quantitative treatment limitations (such as the number of treatments, visits or days of coverage). Such benefit plan also will comply with other applicable parity-related requirements for any non-quantitative treatment limitations (such as medical management standards). However, this should not be construed to require UnityPoint to provide any coverage for any mental health or substance use disorder benefits under any benefit plan, except as required by applicable law. Please refer to the applicable benefit plan materials or designated SPD materials, if any, for additional information.

Special Rights under GINA. The Genetic Information Nondiscrimination Act of 2008, as amended ("*GINA*"), contains certain requirements for group health plans and health insurance issuers prohibiting genetic discrimination, required genetic testing, purchasing or collecting genetic information and disclosure of genetic information except in limited circumstances. In the unlikely event that any genetic information is received by the Company, it will be maintained confidentially.

Physician Designation Notice. The Plan option in which you are enrolled may require or allow for the designation of a primary care provider for you and your enrolled dependents. You have the right to designate any primary care provider who participates in the plan option's network and who is available to accept you or your family members, including a pediatrician (in the case of children), as the primary

care provider. Until you make this designation, the Plan option may designate a primary care provider for you or your covered dependents.

You do not need prior authorization from the Plan option or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the plan option's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

To determine if these rules apply to your Plan option or to a Plan option that you are considering, or for information on how to select a primary care provider, or for a list of participating primary care providers or health care professionals who specialize in obstetrics or gynecology, contact the Third Party Administrator.

Privacy Rights. The Health Insurance Portability and Accountability Act of 1996 and its applicable regulations (HIPAA) is a federal law that, in part, requires health plans such as the medical, dental, and vision plans to protect the privacy and security of your confidential health information. Pursuant to the HIPAA privacy rules, the Health Plan and insurance carriers will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, plan administration or as required or permitted by law. A description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the Notice of Privacy Practices, which has been furnished to you. You can obtain another copy of the Plan's Notice of Privacy Practices from the Employer.