
# Worthington Industries, Inc.

# Worthington Industries Group Welfare Plan
# Summary Plan Description

**Effective**
**January 1, 2023**

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# SECTION I—INTRODUCTION

This document is a description of The Worthington Industries Group Welfare Plan (*Plan*). No oral interpretations can change this *Plan*. The *Plan* described is designed to protect *plan participants* against certain catastrophic health expenses. Terms which have special meanings when used in this *Plan* will be italicized. For a list of these terms and their meanings, please see the **Defined Terms** section of the summary plan description. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise. Coverage under the *Plan* will take effect for an eligible *employee* and designated *dependents* when the *employee* and such *dependents* satisfy the *waiting period* and all of the eligibility requirements of the *Plan*.

The *employer* fully intends to maintain this *Plan* indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the *Plan* at any time and for any reason.

Changes in the *Plan* may occur in any or all parts of the *Plan* including benefit coverage, *deductibles*, maximums, *co-payments*, exclusions, limitations, defined terms, eligibility, and the like.

This *Plan* is not a 'grandfathered health plan' under the *Patient Protection and Affordable Care Act (PPACA)*, also known as Health Care Reform. Questions regarding the *Plan's* status can be directed to the *Plan Administrator*. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1.866.444.3272, or visit **www.dol.gov/ebsa/healthreform**.

Failure to follow the eligibility or enrollment requirements of this *Plan* may result in delay of coverage or no coverage at all. Reimbursement from the *Plan* can be reduced or denied because of certain provisions in the *Plan*, such as coordination of benefits, subrogation, exclusions, timeliness of Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) elections, utilization review or other cost management requirements, lack of *medical necessity*, lack of timely filing of *claims*, or lack of coverage. These provisions are explained in summary fashion in this document. Additional information is available from the *Plan Administrator* at no extra cost.

**Read your benefit materials carefully.** Before you receive any services you need to understand what is covered and excluded under your benefit *Plan*, your cost sharing obligations, and the steps you can take to minimize your out-of-pocket costs. For complete terms of the *Plan* and information about benefits which are not outlined in this summary plan description, refer to your *Plan's* wrap document, which can be obtained from Worthington's People Center. If there is any conflict between this summary plan description and the *Plan's* wrap document, the wrap document will control, unless otherwise specified.

For *employees* covered under a collective bargaining agreement that provides benefits with the *employer*, this plan document does not determine rights under the *Plan*: the collective bargaining agreement always will remain the final authority. In the case of a dispute, the information in the union plan documents or collective bargaining agreement will control to the extent permitted by law. If you are a union *employee* covered under a collective bargaining agreement that provides benefits with the *employer*, you should contact your local Human Resources Representative to obtain a copy of the summary plan description that applies to you.

Review your *Explanation of Benefits* (*EOB*) forms, other *claim* related information, and available *claims* history. *Notify* MyQHealth Care Coordinators of any discrepancies or inconsistencies between amounts shown and amounts you actually paid.

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

No action at law or in equity shall be brought to recover under any section of this *Plan* until the *appeal* rights provided have been exercised and the *Plan* benefits requested in such *appeals* have been denied in whole or in part.

If the *Plan* is terminated or amended, or if benefits are eliminated, the rights of *plan participants* are limited to *covered charges incurred* before termination, amendment, or elimination.

A *plan participant* should contact the *Plan Administrator* to obtain additional information, free of charge, about *Plan* coverage of a specific benefit, particular drug, treatment, test, or any other aspect of *Plan* benefits or requirements. Refer to the Quick Reference Information Chart for contact information.

**For information regarding the *Plan's* eligibility, enrollment, duties of the *Plan Administrator*, assignment of benefits, HIPAA, and Protected Health Information (PHI) provisions, refer to the *Plan's* wrap document.**

## A. Quick Reference Information Chart

**When you need information, please check this document first. If you need further help, call the appropriate phone number listed in the following Quick Reference Information chart:**

| QUICK REFERENCE INFORMATION | |
|---|---|
| **Information Needed** | **Whom to Contact** |
| **Plan Administrator** | Worthington Industries, Inc.<br>200 Old Wilson Bridge Road<br>Columbus, OH 43085<br>1.877.840.6506 |
| **MyQHealth Care Coordinators Administered by Quantum Health**<br>• Pre-Certification, Concurrent Review, and Case Management<br>• Medical *Claim* Pre- and Post-Service *Appeals*<br>• Eligibility for Coverage<br>• Plan Benefit Information | MyQHealth Care Coordinators<br>5240 Blazer Way<br>Dublin OH 43017<br>1.888.971.7377<br>**WIBenefitsHelp.com** |
| **Provider Network**<br>Names of *Physicians* & *Hospitals*<br>• Network Provider Directory – see website | Anthem BlueCross BlueShield<br>1.800.810.BLUE<br>**anthem.com** |
| **Prescription Drug Program**<br>• Retail Network Pharmacies<br>• Mail Order (Home Delivery) Pharmacy<br>• Prescription Drug Information & Formulary<br>• Preauthorization of Certain Drugs<br>• Reimbursement for Non-Network Retail Pharmacy | **Primary PBM: Worthington Industries Onsite Pharmacy**<br>Phone: 1.800.944.4515<br>**WIBenefitsHelp.com**<br><br>**Secondary PBM: Navitus**<br>Phone: 1.855.673.6504<br><br>**Specialty Medications: Lumicera**<br>Member Inquiries: 1.855.847.3553<br>Providers: 1.855.847.3554<br>Fax: 1.855.847.3558<br><br>**Mail Order (Home Delivery) Pharmacy**<br>• **Worthington Industries Pharmacy** is licensed to provide mail order in the following states: AL, FL, GA, IN, IL, IA, KS, KY, MA, MD, MI, MN, MS, NV, NY, NC, ND, OH, OK, PA, RI, SC, SD, TN, UT, and WI.<br>Call 800.944.4515 or visit WINet for more information<br>• If you live in a state not licensed, call Navitus Home Delivery (Birdi) at 1.888.240.2211 |
| **Health Savings Account (HSA)** | HealthEquity<br>1.866.346.5800<br>**my.healthequity.com** |
| **Health Reimbursement Account (HRA)** | HealthEquity<br>1.866.346.5800<br>**my.healthequity.com** |
| **Cost and Quality Transparency Tool** | Care Finder<br>1.888.971.7377<br>**WIBenefitsHelp.com** |
| **Wellness Program** | Worthington Amped Wellness Program<br>MyQHealth Care Coordinators<br>5240 Blazer Way<br>Dublin OH 43017<br>1.888.971.7377<br>**WIBenefitsHelp.com** |

| | |
|---|---|
| **Telemedicine** | LiveHealth Online<br>1.855.603.7985<br>**livehealthonline.com** |
| **COBRA Administrator**<br>• Continuation Coverage | WEX<br>P.O. Box 2798<br>Omaha, NE 68103<br>Phone: 1.877.837.5017<br>**mypremiumbill.com** |
| **Employee Assistance Program (EAP)**<br>• EAP Counseling, Referral and Work/Life Services | SupportLinc<br>1.888.881.5462<br>**supportlinc.com**<br>Code: worthington |

## B. Plan Administrator

The *employer* is the *Plan Administrator*. The name, address, and telephone number of the *Plan Administrator* are:

Worthington Industries, Inc.
200 Old Wilson Bridge Road
Columbus, OH 43085
1.877.840.6506

The *Plan* is administered by the *Plan Administrator* within the purview of Employee Retirement Income Security Act of 1974 (ERISA), and in accordance with these provisions. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* shall appoint a new *Plan Administrator* as soon as reasonably possible.

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

Service of legal process may be made upon the *Plan Administrator*.

## C. Amending and Terminating the Plan

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

Any such amendment, suspension, or termination shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which shall be acted upon as provided in the *Plan Sponsor's* Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. *Notice* shall be provided as required by ERISA.

If the *Plan Sponsor* is a different type of entity, then such amendment, suspension, or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the *Plan Sponsor* is a sole proprietorship, then such action shall be taken by the sole proprietor, in his/her own discretion.

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

### D. Plan Administrator Compensation

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

### E. Fiduciary Duties

A fiduciary must carry out his/her duties and responsibilities for the purpose of providing benefits to the *employees* and their *dependent(s)* and defraying *reasonable* expenses of administering the *Plan*. These are duties which must be carried out:

1. with care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation
2. by diversifying the investments of the *Plan* so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so
3. in accordance with the plan documents to the extent that they agree with *ERISA*

### F. The Named Fiduciary

A named fiduciary is the one named in the *Plan*. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the *Plan*. These other persons become fiduciaries themselves and are responsible for their acts under the *Plan*. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless one (1) of the following occurs:

1. The named fiduciary has violated its stated duties under *ERISA* in appointing the fiduciary, establishing the procedures to appoint the fiduciary, or continuing either the appointment or the procedures.
2. The named fiduciary breached its fiduciary responsibility under Section 405(a) of *ERISA*.

Worthington Industries, Inc.
200 Old Wilson Bridge Road
Columbus, OH 43085
1.877.840.6506

### G. Type of Administration

The *Plan* is a self-funded group health plan, and the *claims* administration is provided through a *Claims Administrator*. The *Plan* is not insured.

### H. Employer Information

The *employer's* legal name, address, telephone number, and federal Employer Identification Number are:

Worthington Industries, Inc.
200 Old Wilson Bridge Road
Columbus, OH 43085
1.877.840.6506
EIN 31-1189815

### I. Plan Name

The name of the *Plan* is the Worthington Industries Group Welfare Plan.

### J. Plan Number

501

### K. Type of Plan

The *Plan* is commonly known as an employee welfare benefit plan. The *Plan* has been adopted to provide *plan participants* certain benefits as described in this document. The Worthington Industries Group Welfare Plan is to be administered by the *Plan Administrator* in accordance with the provisions of ERISA Section 4(a).

### L. Plan Year

The *plan year* is the twelve (12) month period beginning January 1 and ending December 31.

### M. Plan Effective Date

January 1, 2023

### N. Plan Sponsor

The *employer* is the *Plan Sponsor*.

### O. Claims Administrator

The *Plan Administrator* has contracted with a *Claims Administrator* to assist the *Plan Administrator* with *claims* adjudication.

A *Claims Administrator* is not a fiduciary under the *Plan*.

### P. Employer's Right to Terminate

The *employer* reserves the right to amend or terminate this *Plan* at any time. Although the *employer* currently intends to continue this *Plan*, the *employer* is under absolutely no obligation to maintain the *Plan* for any given length of time. If the *Plan* is amended or terminated, an authorized officer of the *employer* will sign the documents with respect to such amendment or termination.

### Q. Agent for Service of Legal Process

The name of the person designated as agent for service of legal process and the address where a processor may serve legal process upon the *Plan* are:

Worthington Industries, Inc.
200 Old Wilson Bridge Road
Columbus, OH 43085
1.877.840.6506

# SECTION II—ELIGIBILITY

**For more information regarding the Plan's eligibility and enrollment provisions, refer to the Plan's wrap document.**

## A. Eligibility

### Eligible Classes of Dependents

A *dependent* is any of the following persons:

1. a covered *employee's* spouse

   The term 'spouse' shall mean the *employee's* legal spouse in a marriage recognized by the Internal Revenue Service for federal income tax purposes. The *Plan Administrator* may require documentation proving a legal marital relationship.

2. a covered *employee's* child(ren)

   For the purposes of the *Plan*, an *employee's* child includes *employee's* child by birth, adoption, placement for adoption, marriage (i.e., a stepchild), or foster care placement (i.e., a foster child), through the last day of the month of the child's 26th birthday.

   Unless otherwise specified, an *employee's* child will be an eligible *dependent* until reaching the limiting age of twenty-six (26), without regard to student status, marital status, financial dependency, or residency status with the *employee* or any other person. The phrase 'placed for adoption' refers to a child whom a person intends to adopt, whether or not the adoption has become final, and who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term 'placed' means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption, and the legal process must have commenced.

3. a covered *employee's* qualified *dependents*

   The term 'qualified *dependents*' shall include children for whom the *employee* is a *legal guardian* as of age 18, provided the *employee* can claim the child as his/her tax dependent. To be eligible for *dependent* coverage under the *Plan*, a qualified *dependent* must be under the limiting age of twenty-six (26) years.

   The *Plan Administrator* may require documentation proving eligibility for *dependent* coverage, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

4. a covered *dependent* child or covered qualified *dependent* who reaches the limiting age and is *totally disabled*, incapable of self-sustaining employment by reason of mental or physical disability, primarily dependent upon the covered *employee* for support and maintenance, and is unmarried

   The *Plan Administrator* may require, at reasonable intervals, continuing proof of the *total disability* and dependency.

   Certification of the disability is required within thirty (3) days of attainment of age twenty-six (26). The *Plan Administrator* reserves the right to have such *dependent* examined by a *physician* of the *Plan Administrator's* choice, at the *Plan's* expense, to determine the existence of such incapacity. You must notify the *Claims Administrator* and/or the *Plan Administrator* if the *dependent's* marital or tax exemption status changes and they are no longer eligible for continued coverage.

### Ineligible Dependent(s)

Unless otherwise provided in this summary plan description, the following are not considered eligible *dependents*:

1. other individuals living in the covered *employee's* home, but who are not eligible as defined
2. the legally separated or divorced former spouse of the *employee*
3. any person who is on active duty in any military service of any country for more than twelve (12) months
4. any other person not defined above in the subsection entitled Eligible Classes of Dependents

**Restrictions on Elections**

If a *plan participant* changes status from *employee* to *dependent* or *dependent* to *employee*, and the person is covered continuously under this *Plan* before, during, and after the change in status, credit will be given for *deductibles,* and all amounts will be applied to maximums.

If two (2) *employees* (spouses) are covered under the *Plan* and the *employee* who is covering the *dependent* children terminates coverage, the *dependent* coverage may be continued by the other covered *employee* with no *waiting period* as long as coverage has been continuous.

Accumulators will transfer if a *dependent* changes from coverage under one parent *employee* to coverage under another parent *employee*.

At any time, the *Plan* may require proof that a spouse, domestic partner, qualified *dependent,* or a child qualifies or continues to qualify as a *dependent* as defined by this *Plan*.

# SECTION III—CONSOLIDATED APPROPRIATIONS ACT OF 2021 AND TRANSPARENCY IN COVERAGE REGULATIONS

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act. In addition, the Transparency in Coverage (TIC) regulations contain transparency requirements. Portions of the CAA and TIC are described briefly below. Enforcement dates, standards for implementation, coordination with other entities, legal developments, and updates offered by federal and/or state entities directly impact actions and availability of the items described. In addition, some plan types are not subject to the CAA and/or TIC, or certain provisions of either.

## A. Surprise Billing Claims

*Surprise billing* claims are claims that are subject to the No Surprises Billing Act requirements. These are:

1. *emergency services* provided by *non-network* providers or facility
2. covered services provided by a *non-network* provider at a *network* facility
3. *non-network* air ambulance services

The section below contains further information about how these *claim* categories apply to your *Plan*.

## B. No Surprises Billing Act Requirements

### Emergency Services

As required by the CAA, *emergency services* are covered under your *Plan*:

1. without the need for *pre-certification*
2. whether the provider is *network* or *non-network*

If the *emergency services* you receive are provided by a *non-network* provider or facility, covered services will be processed at the *network* benefit level in accordance with the CAA.

Note that if you receive *emergency services* from a *non-network* provider or facility, your out-of-pocket costs will be limited to amounts that would apply if the covered services had been furnished by a *network* provider or facility. However, *non-network cost-sharing amounts* (i.e., *co-payments*, *deductibles*, and/or *co-insurance*) will apply to your *claim* if the treating *non-network* provider or facility determines you are stable and the *non-network* provider satisfies all of the following requirements:

1. determines that you are able to travel to a *network* facility by non-emergency or non-medical transport to an available *network* provider or facility within a reasonable distance based on your condition
2. complies with the *notice* and consent requirement
3. determines that you are in condition to receive the information and provide informed consent

If you continue to receive services from the *non-network* provider after you are stabilized, you will be responsible for the *non-network cost-sharing amounts*, and the *non-network* provider will also be able to charge you any difference between the *maximum allowable amount* and the *non-network* provider's billed charges.

### Non-Network Services Provided at a Network Facility

When you receive covered services from a *non-network* provider at a *network* facility, your *claims* will be paid at the *non-network* benefit level if the *non-network* provider gives you proper *notice* of its charges, and you give written consent to such charges. This means you will be responsible for *non-network cost-sharing amounts* for those services and the *non-network* provider can also charge you any difference between the *maximum allowable amount* and the *non-network* provider's billed charges.

This requirement does not apply to ancillary services. Ancillary services are defined as:

1. items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a *physician* or non-physician practitioner
2. items and services provided by assistant surgeons, hospitalists, and intensivists
3. diagnostic services, including radiology and laboratory services

4. items and services provided by a *non-participating provider* if there is no *participating provider* who can furnish such item or service at such facility

This *notice* and consent exception also does not apply if the covered services furnished by a *non-network* provider result from unforeseen and urgent medical needs arising at the time of service.

*Non-network* providers satisfy the *notice* and consent requirement by one (1) of the following:

1. by obtaining your consent and offering the required notice not later than seventy-two (72) hours prior to the delivery of services
2. the *notice* is given and consent is obtained on the date of the service, if you make an appointment within seventy-two (72) hours of the services being delivered

To help you determine whether a provider is *non-network*, the *network* is required to confirm the list of *network* providers in its provider directory every ninety (90) days. If you can show that you received inaccurate information from the *network* that a provider was *in-network* on a particular *claim*, then you will only be liable for *network cost sharing amounts* (i.e., *co-payments*, *deductibles*, and/or *co-insurance*) for that *claim*. Your *network cost-sharing amount* will be calculated based upon the *maximum allowed amount*. In addition to your *network* cost-share, the *non-network* provider can also charge you for the difference between the *maximum allowed amount* and their billed charges.

### C. How Cost-Shares Are Calculated

Your *cost sharing amounts* for emergency services or for covered services received by a *non-network* provider at a *network* facility will be calculated as defined by the CAA, such as the median plan *network* contract rate that we pay *network* providers for the geographic area where the covered service is provided if other calculation criteria does not apply. Any out-of-pocket cost you pay to a *non-network* provider for either *emergency services* or for covered services provided by a *non-network* provider at a *network* facility will be applied to your *network out-of-pocket limit*.

### D. Appeals

If you receive *emergency services* from a *non-network* provider or covered services from a *non-network* provider at a *network* facility and believe those services are covered by the No Surprise Billing Act, you have the right to appeal that *claim*. If your appeal of a *surprise billing claim* is denied, then you have a right to appeal the adverse decision to an independent review organization as set out in the **Claims and Appeals** section of this summary plan description. A provider can dispute the payment they received from the *Plan* by utilizing a process set up the CAA, or if applicable, state law. The CAA process includes Open Negotiation, and if unresolved, Independent Dispute Resolution. Importantly, this process does not include the *plan participant*, and you are not required to participate. To learn more about the CAA, you can visit **https://www.cms.gov/nosurprises**.

### E. Transparency Requirements

1. Under your *Plan*, the following are provided as required by the CAA and TIC. Depending on how the *Plan* interacts with other entities, these may be provided from the Care Coordinators, the *network*, Pharmacy Benefit Manager, and/or other stakeholders (ex. Customer Care or Member Services): protections with respect to *surprise billing claims* by providers
2. estimates on what *non-network* providers may charge for a particular service
3. information on contacting state and federal agencies in case you believe a provider has violated the No Surprise Billing Act's requirements

When asked, a paper copy of the type of information you request from the above list can be provided.

Through the price comparison/shoppable services tool(s) associated with your *Plan* or through Member Services at the phone number on the back of your ID card, you can receive the following:

1. cost sharing information that you would be responsible for, for a service from a specific *network* provider
2. a list of all *network* providers
3. cost sharing information on a *non-network* provider's services based on the *network's* reasonable estimate based on what the *network* would pay a *non-network* provider for the service

As applicable, under machine readable requirements from the TIC, the *network*, Pharmacy Benefit Manager, *Third Party Administrator*, and/or entities associated with your *Plan* will provide access through separate publicly accessible websites that contain the following information:

1. *network* negotiated rates
2. historical *non-network* allowed amounts
3. drug pricing information

**F. Continuity of Care**

If a *network* provider leaves the *network* for any reason other than termination for failure to meet applicable quality standards, fraud, or otherwise defined by the CAA, you may be able to continue seeing that provider for a limited period of time and still receive *network* benefits. The CAA permits you to request and decide to continue to have benefits provided under the same terms and conditions as you would have had under the plan document had the provider not moved to *non-network* status. If authorized, continuity of care ends ninety (90) days after you are notified by the *Plan* or its delegate of the right to request continuity of care or the date you are no longer under care of the provider, whichever of these is earlier.

Continuity of care under the CAA is permitted for a *plan participant* who, with respect to a provider, qualifies based on any of the following circumstances:

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility
2. is undergoing a course of institutional or inpatient care from the provider or facility
3. is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility

Under the CAA, the term 'serious and complex condition' means, with respect to a *participant*, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage, one (1) of the following:

1. in the case of an acute *illness*, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm
2. in the case of a chronic *illness* or condition, a condition that satisfies both of the following criteria:
    a. is life-threatening, degenerative, potentially disabling, or congenital
    b. requires specialized medical care over a prolonged period of time

If you wish to continue seeing the same provider/facility and you believe continuity of care under the CAA applies, you or your provider/facility should contact the entity responsible for Member Services on back of your card for how to apply for continuity of care.

# SECTION IV—MEDICAL NETWORK INFORMATION

## A. Network and Non-Network Services

### Network Provider Information

The *Plan* has entered into an agreement with a medical *network* that maintains contractual agreements with certain *hospitals*, *physicians*, and other health care providers which are called *network* providers. Because these *network* providers have agreed to charge reduced fees to persons covered under the *Plan*, the *Plan* can afford to reimburse a higher percentage of their fees.

Therefore, when a *plan participant* uses a *network* provider, that *plan participant* will receive better benefits from the *Plan* than when a *non-network* provider is used. It is the *plan participant's* choice as to which provider to use.

### Non-Network Provider Information

*Non-network* providers have no agreements with the *Plan* or the *Plan's* medical *network* and are generally free to set their own charges for the services or supplies they provide. The *Plan* will reimburse for the *allowable charges* for any *medically necessary* services or supplies, subject to the *Plan's deductibles*, *co-insurance*, *co-payments*, limitations, and exclusions. *Plan participants* must submit proof of *claim* before any such reimbursement will be made.

Before you obtain services or supplies from a *non-network* provider, you can find out whether the *Plan* will provide *network* or *non-network* benefits for those services or supplies by contacting MyQHealth Care Coordinators as outlined in the Quick Reference Information Chart.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *balance billing/surprise billing*.

### Provider Non-Discrimination

To the extent that an item or service is a *covered charge* under the *Plan*, the terms of the *Plan* shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable state law. This provision does not preclude the *Plan* from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided, and does not require the *Plan* to accept all types of providers as a *network* provider.

## B. Choosing a Physician – Patient Protection Notice

The *Plan* does not require you to select a primary care physician (PCP) to coordinate your care, and you do not have to obtain a referral to see a specialist.

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

## C. Special Reimbursement Provisions

Under the following circumstances, the higher *network* payment will be made for certain *non-network* services:

1. **Medical Emergency.** In a *medical emergency*, a *plan participant* should try to access a *network* provider for treatment. However, if immediate treatment is required and this is not possible, the services of *non-network* providers will be covered until the *plan participant's* condition has stabilized to the extent that they can be safely transferred to a *network* provider's care. At that point, if the transfer does not take place, *non-network* services will be covered at *non-network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* MyQHealth Care Coordinators for a review of any *claim* that meets this definition.
2. **No Choice of Provider.** If, while receiving treatment at a *network* facility a *plan participant* receives ancillary services or supplies from a *non-network* provider in a situation in which they have no control over provider selection (such as in the selection of an ambulance, emergency room *physician*, anesthesiologist, assistant surgeon, radiologist, pathologist, or a provider for *diagnostic services*), such *non-network* services or supplies

will be covered at *network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* MyQHealth Care Coordinators for a review of any *claim* that meets this definition. Blood work sent to a *non-network* lab will not be considered at the *network* benefit.

3. **Providers Outside of Network Area.** If *non-network* providers are used because the necessary specialty is not in the *network* or is not reasonably accessible to the *plan participant* due to geographic constraints [over fifty (50) miles from home], such *non-network* care will be covered at *network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* MyQHealth Care Coordinators for a review of any *claim* that meets this definition.

Additional information about this option, as well as a list of *network* providers, will be given to *plan participants*, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *balance billing/surprise billing*.

### D. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call the *Claims Administrator* to find out Your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health Identification Card with You.

When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global Core Service Center any time. They are available twenty-four (24) hours a day, seven (7) days a week. The toll free number is 1.800.810.2583. Or you can call them collect at 1.804.673.1177.

If you need inpatient hospital care, you or someone on your behalf should contact MyQHealth Care Coordinators for *pre-certification* as outlined in the Quick Reference Information Chart. Keep in mind, if you need emergency medical care, go to the nearest *hospital*. There is no need to call before you receive care.

Please refer to the **Health Care Management Program** *pre-certification* provisions in this booklet for further information. You can learn how to get *pre-certification* when you need to be admitted to the *hospital* for emergency or non-emergency care.

#### How Claims are Paid with Blue Cross Blue Shield Global Core

In most cases, when You arrange *inpatient hospital* care with Blue Cross Blue Shield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any *co-payment*, *co-insurance*, or *deductible* amounts that may apply.

You will typically need to pay for the following services up front:

1. doctor services
2. *inpatient hospital* care not arranged through Blue Cross Blue Shield Global Core
3. *outpatient* services

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core claim forms, you can get international claims forms in the following ways:

1. call the Blue Cross Blue Shield Global Core Service Center at the numbers above
2. online at www.bcbsglobalcore.com

You will find the address for mailing the claim on the form.

### E. Network Information

You may obtain more information about the providers in the *network* by contacting the *network* by phone or by visiting their website.

**Anthem BlueCross BlueShield**

1.800.810.BLUE

**anthem.com**

**All locations**

# SECTION V—SCHEDULE OF BENEFITS

## A. Verification of Eligibility: 1.888.971.7377

Call this number to verify eligibility for *Plan* benefits **before** charges are *incurred*. Please note that oral or written communications with MyQHealth Care Coordinators regarding a *plan participant's* or beneficiary's eligibility or coverage under the *Plan* are not *claims* for benefits, and the information provided by MyQHealth Care Coordinators or other *Plan* representative in such communications does not constitute a certification of benefits or a guarantee that any particular *claim* will be paid. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this summary plan description.

## B. Schedule of Benefits

All benefits described in the Schedules of Benefits are subject to the exclusions and limitations described more fully herein, including, but not limited to, the *Plan Administrator's* determination that care and treatment is *medically necessary*; that charges are in accordance with the *maximum allowable charge*; and that services, supplies, and care are not *experimental/investigational*.

This document is intended to describe the benefits provided under the *Plan,* but due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all *covered charges* and/or exclusions with specificity. If you have questions about specific supplies, treatments, or procedures, please contact MyQHealth Care Coordinators as outlined in the Quick Reference Information Chart.

The *Plan Administrator* retains the right to audit *claims* to identify treatment(s) that are, or were, not *medically necessary*, *experimental*, *investigational*, or not in accordance with the *maximum allowable charges*.

### Pre-Certification

The following services must be *pre-certified*, or reimbursement from the *Plan* may be denied:

1. *inpatient* and skilled nursing facility admissions
2. *outpatient* surgeries
3. MRI/MRA and pet scans
4. oncology care and services (chemotherapy and radiation therapy)
5. genetic testing, genomic testing, and gene therapy
6. home health care
7. hospice care
8. durable medical equipment (DME) – all rentals and any purchase over $1,500
9. organ, tissue, and bone marrow transplants
10. dialysis
11. *applied behavioral analysis (ABA)* therapy
12. partial hospitalization and intensive outpatient for mental health/substance use disorder

Services rendered in an emergency room or urgent care setting do not require *pre-certification*.

**Please see the Care Coordination Program section in this document for details.**

## C. Deductible Amount

*Deductibles* are dollar amounts that the *plan participant* must pay before the *Plan* pays. Before benefits can be paid in a *calendar year,* a *plan participant* must meet the *deductible* shown in the applicable Schedule of Medical Benefits.

This amount will accrue toward the 100% maximum *out-of-pocket limit*.

### D. Benefit Payment

Each *calendar year*, benefits will be paid for the *covered charges* of a *plan participant* that are in excess of the *deductible*, any *co-payments,* and any amounts paid for the same services. Payment will be made at the rate shown under the reimbursement rate in the applicable Schedule of Medical Benefits. No benefits will be paid in excess of the *maximum benefit* amount or any listed limit of the *Plan*.

Services rendered may have professional, facility, and other components for which *physicians* and facilities may bill separately.

### E. Out-of-Pocket Limit

*Covered charges* are payable at the percentages shown each *calendar year* until the *out-of-pocket limit* shown in the applicable Schedule of Medical Benefits is reached. Then, *covered charges incurred* by a *plan participant* will be payable at 100% (except for the charges excluded) for the remainder of the *calendar year*.

The *out-of-pocket limit* includes applicable amounts paid for *deductibles, co-payments*, and *co-insurance*.

### F. Diagnosis-Related Grouping (DRG)

*Diagnosis related grouping* (*DRG*) is a method for reimbursing *hospitals* for *inpatient* services. This is when a provider bills for services that go together in a group, or bundle, instead of the individual services that make up the group separately. The provider has agreed to a set *DRG* rate with the *network*. When a service is rendered, regardless of what the provider bills, the *DRG* amount has already been set for that specific group of services. A *DRG* amount can be higher or lower than the actual billed charge because it is based on an average cost for the services rendered.

In the case where the *DRG* amount on an eligible *claim* is higher than the actual billed charges, the following will determine how each party's cost sharing will be determined:

1. the *Plan* will base their portion of the charge on the *network allowed amount*
2. the *plan participant's* portion of the charge will be based on the billed charges
3. the difference in the *network allowed amount* versus the actual billed charges will be the responsibility of the *Plan*

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *balance billing/surprise billing*.

### G. Co-Insurance

For *covered charges incurred* with a *network* provider, the *plan participant* pays a specified percentage of the negotiated rate. This percentage varies, depending on the type of *covered charge*, and is specified in the applicable Schedule of Medical Benefits. You are responsible for the difference between the percentage the *Plan* pays and 100% of the negotiated rate.

For *covered charges incurred* with a *non-network* provider, the *Plan* pays a specified percentage of *covered charges* at the *maximum allowable charge*. In those circumstances, you are responsible for the difference between the percentage the *Plan* pays and 100% of the billed amount, unless your *claim* is a *surprise billing claim*.

These amounts for which you are responsible are known as *co-insurance*. Unless noted otherwise in the Special Comments column of the applicable Schedule of Medical Benefits, your *co-insurance* applies towards satisfaction of the *out-of-pocket limit*.

### H. Balance Bill

The *balance bill* refers to the amount you may be charged for the difference between a *non-network* provider's billed charges and the *allowable charge*.

*Network* providers will accept the *allowable charge* for *covered charges*. They will not charge you for the difference between their billed charges and the *allowable charge*.

*Non-network* providers have no obligation to accept the *allowable charge*. You are responsible to pay a *non-network* provider's billed charges, even though reimbursement is based on the *allowable charge*. Depending on what billing arrangements you make with a *non-network* provider, the provider may charge you for full billed charges at the time of

service or seek to *balance bill* you for the difference between billed charges and the amount that is reimbursed on a *claim*.

Any amounts paid for *balance bills* do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *balance billing/surprise billing*.

Refer to the **Prescription Drug Benefits** section of this summary plan description for additional information on *prescription drug* coverage.

## I. High Deductible Health Plan (HDHP)

For more provisions pertaining to *health savings accounts (HSA)*, refer to the *Plan's* wrap document.

You can pay your *deductible* with funds from your *HSA*, or you can choose to pay your *deductible* out-of-pocket, allowing your *health savings account* to grow. **Preventive care services are not subject to the *deductible*. These benefits are paid at 100%.**

### Applying Expenses to the Deductible

If you have not met your *deductible*, you will be responsible for 100% of the *allowed amount* for your health care expenses. If you use a *network* provider, the provider will submit the *claim* to the *Claims Administrator* on your behalf. If you use a *non-network* provider, your *physician* may ask you to pay for the services provided before you leave the office. In that case, you must submit your *claim* to MyQHealth Care Coordinators to ensure your expenses are applied to the *deductible*. You will subsequently receive an *Explanation of Benefits* from the *Claims Administrator* stating how much the negotiated payment amount is and the amount you are responsible for.

## J. Requirements for a Health Savings Account (HSA)

To be eligible for enrollment in a *health saving account*, you must:

1. be enrolled in a qualified *HDHP*
2. in general, not have any other non-*HDHP* medical coverage including coverage under a health flexible spending account or health reimbursement account

   You are allowed to have auto, dental, vision, disability, and long-term care insurance at the same time as an *HDHP*.
3. not be enrolled in a general purpose health care flexible spending account (and your spouse may not be enrolled in a general purpose flexible spending account)
4. not be enrolled in *Medicare*
5. not be claimed as a *dependent* on someone else's tax return

### Qualified Medical Expenses

A partial list is provided in IRS Publication 502, available at **www.irs.gov**.

## K. Schedule of Medical Benefits –HSA Blue Plan Option

| | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|
| **Deductible, per Calendar Year**<br>The *network* and *non-network deductible* amounts accumulate towards each other. | | |
| Employee Only | $1,500 | |
| Family | $3,000 | |
| **Family Unit - Non-Embedded Deductible**<br>If you are enrolled in family coverage, there is not an individual *deductible* embedded in the *family* coverage *deductible*. Before your *Plan* helps you pay for any of your medical bills, the entire amount of the *family unit deductible* must be met first. It can be met by one (1) family member or a combination of family members; however, there are no benefits (except for *preventive care*) until expenses equaling the *family* coverage *deductible* amount have been *incurred*.<br>**For example,** if you, your spouse, and child are on a family plan with a $3,000 *family* coverage non-embedded *deductible* and the individual *deductible* is $1,500, and your child *incurs* $1,500 in medical bills, your *Plan* will NOT help pay subsequent medical bills until the *family* coverage *deductible* of $3,000 has been met yet. | | |
| **Maximum Out-of-Pocket Limit, per Calendar Year**<br>The *out-of-pocket limit* includes *co-insurance*, *deductibles,* and covered *prescription drug* charges.<br>The *network* and *non-network out-of-pocket limits* accumulate towards each other. *Prescription drug* charges accumulate toward both the *network* and *non-network out-of-pocket limit*. | | |
| Employee Only | $3,500 | $5,000 |
| Family | $7,000 | $10,000 |
| **Family Unit - Non-Embedded Out-of-Pocket Limit**<br>If you are enrolled in *family* coverage, there is not an individual *out-of-pocket limit* embedded in the *family* coverage *out-of-pocket limit*. Before your *covered charges* are payable at 100% (except for the charges excluded), the entire amount of the *family* coverage *out-of-pocket limit* must be met first. It can be met by one (1) family member or a combination of family members. When a *family* reaches the *out-of-pocket limit*, *covered charges* for that *family* will be payable at 100% (except for the charges excluded) for the remainder of the *calendar year*. | | |
| The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached, at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise.<br>**NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the *Plan*:**<br>1. cost containment penalties<br>2. amounts over *the maximum allowable charges*<br>3. charges not covered under the *Plan*<br>4. *balanced billed* charges<br>5. charges for services that are not *medically necessary* | | |

Benefits are shown as the percentage the *Plan* will pay.

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **General Percentage Payment Rule** | 80% after *deductible* | 60% after *deductible* | Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply. |
| **Acupuncture** | 80% after *deductible* | | **Calendar Year Maximum:** Twenty (20) visits per *plan participant*. |
| **Advanced Imaging** | 80% after *deductible* | 60% after *deductible* | Includes: 3D mammograms, Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, SPECT scans, and PET scans, excluding services rendered in an emergency room setting.<br>***Pre-certification* is required for MRI/MRA and PET scans.** |
| **Allergy Services** | | | |
| Allergy Testing | 80% after *deductible* | 60% after *deductible* | |
| Allergy Treatment | 80% after *deductible* | 60% after *deductible* | |
| **Ambulance Service** | 80% after *deductible* | | Air ambulance will suspend for *medical necessity*. |
| **Chemotherapy Drugs/Infusions and Radiation Treatments** | 80% after *deductible* | 60% after *deductible* | This benefit applies for all covered *medically necessary* diagnoses.<br>***Pre-certification* is required.** |
| **Chiropractic Treatment** | 80% after *deductible* | 60% after *deductible* | **Calendar Year Maximum:** Twenty (20) visits per *plan participant*, *network* and *non-network* combined. Spinal manipulations apply to the rendering provider benefit maximum. |
| **Clinical Trials** | 80% after *deductible* | 60% after *deductible* | Refer to **Medical Benefits** section for details. |
| **Consultation/Second Surgical Opinion** | 80% after *deductible* | 60% after *deductible* | |
| **Dental Injury and Oral Surgery** | 80% after *deductible* | 60% after *deductible* | |
| **Diabetic Equipment** | 80% after *deductible* | | |
| **Diagnostic Testing, Lab, and X-Ray** | 80% after *deductible* | 60% after *deductible* | |
| **Durable Medical Equipment (DME)** | | | |
| Durable Medical Equipment | 80% after *deductible* | | ***Pre-certification* is required for all rentals and any purchase in excess of $1,500.** |
| Diabetic Equipment | 80% after *deductible* | | |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Emergency Room** | 80% after *deductible* | | Emergency room professional fees will be based on the *maximum allowable charges*. |
| **Hearing** | 80% after *deductible* | 60% after *deductible* | Includes surgically implanted hearing aid devices and non-routine medical hearing care. |
| **Home Health Care** | 80% after *deductible* | 60% after *deductible* | Includes home infusion therapy.<br>***Pre-certification* is required.** |
| **Hospice Care** | | | |
| Hospice Care | 100% after *deductible* | 100% after *deductible* | *Hospice care services and supplies* for *plan participants* with a life expectancy of less than twelve (12) months.<br>***Pre-certification* is required.** |
| Bereavement Counseling | | | Counseling for covered family members limited to one (1) year after a *plan participant's* death. |
| **Injections and Infusion Therapy** | 80% after *deductible* | 60% after *deductible* | Benefits are available for injections and infusion therapies received in an office setting or other covered facility. |
| **Inpatient Hospital** | | | |
| Physician Visits | 80% after *deductible* | 60% after *deductible* | |
| Room and Board | 80% after *deductible* | 60% after *deductible* | Limited to the semi-private room rate when such semi-private room rate is available.<br>***Pre-certification* is required.** |
| **Maternity and Reproductive Care** | | | |
| Initial Office Visit | 80% after *deductible* | 60% after *deductible* | *Dependent* child *pregnancy* is covered.<br>Includes coverage for therapeutic abortions, contraceptives not covered under preventive care, diagnostic testing and treatment for infertility, and sterilization services, including vasectomy.<br>All other *covered charges* billed by the *physician* for maternity care.<br>***Pre-certification* is required** for inpatient procedures, surgical services, and maternity or newborn stays exceeding forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean section. |
| All Other Services | 80% after *deductible* | 60% after *deductible* | |
| Labor and Delivery | 80% after *deductible* | 60% after *deductible* | |
| **Medical Supplies** | 80% after *deductible* | | |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Mental Disorders & Substance Use Disorder** | | | |
| ADD/ADHD | 80% after *deductible* | 60% after *deductible* | Includes autistic disease, mental retardation, *developmental delays*, and learning disabilities. |
| Inpatient | 80% after *deductible* | 60% after *deductible* | Includes detox and residential treatment.<br>***Pre-certification* is required.** |
| Outpatient | 80% after *deductible* | 60% after *deductible* | Includes intensive outpatient therapy, *partial hospitalization*, and online visits.<br>***Pre-certification* is required for transcranial magnetic stimulation, intensive outpatient therapy, and partial hospitalization.** |
| **Nutritional Counseling** | 80% after *deductible* | 60% after *deductible* | When *medically necessary* for diabetes, home health care, or hospice. |
| **Obesity Services** | 80% after *deductible* | 60% after *deductible* | ***Pre-certification* is required for surgical services.** |
| **Office/Home Visits** | 80% after *deductible* | 60% after *deductible* | |
| **Online Visits** | 80% after *deductible* | Not Covered | Online visits through LiveHealth Online. Refer to Quick Reference Information Chart for contact information. |
| **Orthotics/Prosthetics** | 80% after *deductible* | 60% after *deductible* | |
| **Outpatient Observation Stays** | 80% after *deductible* | 60% after *deductible* | After twenty-four (24) observation hours, a confinement will be considered at this benefit level. Prior to twenty-four (24) observation hours, benefits will pay at the applicable benefit level. |
| **Outpatient Professional Services** | 80% after *deductible* | 60% after *deductible* | |
| **Outpatient Surgery** | 80% after *deductible* | 60% after *deductible* | ***Pre-certification* is required for *outpatient surgical procedures*** (excluding *outpatient* office *surgical procedures*). |
| **Routine Newborn Care** | 80% after *deductible* | 60% after *deductible* | Routine newborn care is subject to the mother's *deductible* and *out-of-pocket limit*. If the mother is not covered under the *Plan*, then these expenses apply to the covered *employee's deductible* and *out-of-pocket limit*. |
| **Skilled Nursing Facility/ Extended Care** | 80% after *deductible* | 60% after *deductible* | **Calendar Year Maximum:** Sixty (60) days per *plan participant*, *network* and *non-network* combined.<br>Long term acute care and rehabilitation hospital services apply toward this maximum.<br>***Pre-certification* is required.** |
| **Temporomandibular Joint Syndrome (TMJ)** | 80% after *deductible* | 60% after *deductible* | ***Pre-certification* is required for surgical services.** |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Therapy Services, Outpatient** | | | |
| Physical Therapy<br>Occupational Therapy<br>Speech Therapy<br>Cognitive Therapy<br>Vision Therapy | 80% after *deductible* | 60% after *deductible* | **Calendar Year Maximum:** Sixty (60) visits per *plan participant* for physical, speech, occupational, cognitive, and vision therapies combined, unless *medical necessity* requires additional visits. Maximum includes habilitative services.<br>Therapy services apply to the rendering provider benefit maximum. |
| Cardiac Rehabilitation<br>Pulmonary Rehabilitation | 80% after *deductible* | 60% after *deductible* | |
| **Urgent Care** | 80% after *deductible* | 60% after *deductible* | Includes retail health clinics. |
| **Vision Care** | 80% after *deductible* | 60% after *deductible* | Medical vision exam. Does not include routine vision exams or prescription lenses. |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **PREVENTIVE CARE**<br><br>If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network* provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites:<br><br>**https://www.healthcare.gov/coverage/preventive-care-benefits/**<br>**http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**<br>**www.hrsa.gov**<br><br>Non-Preventive Care services which are ordered or performed at a Routine Wellness Care visit are not considered under the Preventive Care benefit. Those services will apply to their applicable benefit level or exclusion as appropriate. | | | |
| **Routine Wellness Care** | 100%,<br>*deductible* waived | 100%,<br>*deductible* waived | Services include routine physical exam, immunizations, gynecological exam, pap smear, PSA test, 2D and 3D mammogram, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. |
| **Breastfeeding Pump and Supplies** | 100%,<br>*deductible* waived | 100%,<br>*deductible* waived | Breastfeeding support, supplies, and counseling. Breast pumps are limited to one (1) per pregnancy and a maximum of $500. ***Pre-certification* is required** for breast pumps exceeding $500 purchase price. |
| **Contraceptive Services** | 100%,<br>*deductible* waived | 100%,<br>*deductible* waived | Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion.<br><br>**Benefit Limitations:** Services are available to all female *plan participants*. |
| **TRANSPLANTS** | | | |
| Organ Transplants<br>Live Donor Health Services | 100% after *deductible* | 80% after *deductible* | Not Covered | Refer to the **Transplant Program** section for a further description and limitations of this benefit.<br><br>All other related services will pay under the applicable benefit level.<br><br>***Pre-certification* is required.** |
| Bone Marrow Donor Search Fee | 100% after *deductible* | 80% after *deductible* | Not Covered | Limited to $30,000 per transplant. |

**Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.**

## L. Schedule of Medical Benefits –HSA Green Plan Option

| | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|
| **Deductible, per Calendar Year**<br>The *network* and *non-network deductible* amounts accumulate towards each other. | | |
| Employee Only | $2,500 | |
| Family | $5,000 | |
| **Family Unit - Non-Embedded Deductible**<br>If you are enrolled in family coverage, there is not an individual *deductible* embedded in the *family* coverage *deductible*. Before your *Plan* helps you pay for any of your medical bills, the entire amount of the *family unit deductible* must be met first. It can be met by one (1) family member or a combination of family members; however, there are no benefits (except for *preventive care*) until expenses equaling the *family* coverage *deductible* amount have been *incurred*.<br>**For example,** if you, your spouse, and child are on a family plan with a $3,000 *family* coverage non-embedded *deductible* and the individual *deductible* is $1,500, and your child *incurs* $1,500 in medical bills, your *Plan* will NOT help pay subsequent medical bills until the *family* coverage *deductible* of $3,000 has been met yet. | | |
| **Maximum Out-of-Pocket Limit, per Calendar Year**<br>The *out-of-pocket limit* includes *co-insurance*, *deductibles,* and covered *prescription drug* charges.<br>The *network* and *non-network out-of-pocket limits* accumulate towards each other. *Prescription drug* charges accumulate toward both the *network* and *non-network out-of-pocket limit*. | | |
| Employee Only | $4,500 | $6,000 |
| Family | $9,000 | $12,000 |
| **Family Unit - Non-Embedded Out-of-Pocket Limit**<br>If you are enrolled in *family* coverage, there is not an individual *out-of-pocket limit* embedded in the *family* coverage *out-of-pocket limit*. Before your *covered charges* are payable at 100% (except for the charges excluded), the entire amount of the *family* coverage *out-of-pocket limit* must be met first. It can be met by one (1) family member or a combination of family members. When a *family* reaches the *out-of-pocket limit*, *covered charges* for that *family* will be payable at 100% (except for the charges excluded) for the remainder of the *calendar year*. | | |
| The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached, at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise.<br>**NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the *Plan*:**<br>1. cost containment penalties<br>2. amounts over *the maximum allowable charges*<br>3. charges not covered under the *Plan*<br>4. *balanced billed* charges<br>5. charges for services that are not *medically necessary* | | |

Benefits are shown as the percentage the *Plan* will pay.

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **General Percentage Payment Rule** | 70% after *deductible* | 50% after *deductible* | Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply. |
| **Acupuncture** | 70% after *deductible* | | **Calendar Year Maximum:** Twenty (20) visits per *plan participant*. |
| **Advanced Imaging** | 70% after *deductible* | 50% after *deductible* | Includes: 3D mammograms, Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, SPECT scans, and PET scans, excluding services rendered in an emergency room setting.<br>***Pre-certification* is required for MRI/MRA and PET scans.** |
| **Allergy Services** | | | |
| Allergy Testing | 70% after *deductible* | 50% after *deductible* | |
| Allergy Treatment | 70% after *deductible* | 50% after *deductible* | |
| **Ambulance Service** | 70% after *deductible* | | Air ambulance will suspend for *medical necessity*. |
| **Chemotherapy Drugs/Infusions and Radiation Treatments** | 70% after *deductible* | 50% after *deductible* | This benefit applies for all covered *medically necessary* diagnoses.<br>***Pre-certification* is required.** |
| **Chiropractic Treatment** | 70% after *deductible* | 50% after *deductible* | **Calendar Year Maximum:** Twenty (20) visits per *plan participant*, *network* and *non-network* combined. Spinal manipulations apply to the rendering provider benefit maximum. |
| **Clinical Trials** | 70% after *deductible* | 50% after *deductible* | Refer to **Medical Benefits** section for details. |
| **Consultation/Second Surgical Opinion** | 70% after *deductible* | 50% after *deductible* | |
| **Dental Injury and Oral Surgery** | 70% after *deductible* | 50% after *deductible* | |
| **Diabetic Equipment** | 70% after *deductible* | | |
| **Diagnostic Testing, Lab, and X-Ray** | 70% after *deductible* | 50% after *deductible* | |
| **Durable Medical Equipment (DME)** | | | |
| Durable Medical Equipment | 70% after *deductible* | | ***Pre-certification* is required for all rentals and any purchase in excess of $1,500.** |
| Diabetic Equipment | 70% after *deductible* | | |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Emergency Room** | 70% after *deductible* | | Emergency room professional fees will be based on the *maximum allowable charges*. |
| **Hearing** | 70% after *deductible* | 50% after *deductible* | Includes surgically implanted hearing aid devices and non-routine medical hearing care. |
| **Home Health Care** | 70% after *deductible* | 50% after *deductible* | Includes home infusion therapy.<br>***Pre-certification* is required.** |
| **Hospice Care** | | | |
| Hospice Care | 100% after *deductible* | 100% after *deductible* | *Hospice care services and supplies* for *plan participants* with a life expectancy of less than twelve (12) months.<br>***Pre-certification* is required.** |
| Bereavement Counseling | | | Counseling for covered family members limited to one (1) year after a *plan participant's* death. |
| **Injections and Infusion Therapy** | 70% after *deductible* | 50% after *deductible* | Benefits are available for injections and infusion therapies received in an office setting or other covered facility. |
| **Inpatient Hospital** | | | |
| Physician Visits | 70% after *deductible* | 50% after *deductible* | |
| Room and Board | 70% after *deductible* | 50% after *deductible* | Limited to the semi-private room rate when such semi-private room rate is available.<br>***Pre-certification* is required.** |
| **Maternity and Reproductive Care** | | | |
| Initial Office Visit | 70% after *deductible* | 60% after *deductible* | *Dependent* child *pregnancy* is covered.<br>Includes coverage for therapeutic abortions, contraceptives not covered under preventive care, diagnostic testing and treatment for infertility, and sterilization services, including vasectomy.<br>All other *covered charges* billed by the *physician* for maternity care.<br>***Pre-certification* is required** for inpatient procedures, surgical services, and maternity or newborn stays exceeding forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean section. |
| All Other Services | 70% after *deductible* | 60% after *deductible* | |
| Labor and Delivery | 70% after *deductible* | 50% after *deductible* | |
| **Medical Supplies** | 70% after *deductible* | | |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Mental Disorders & Substance Use Disorder** | | | |
| ADD/ADHD | 70% after *deductible* | 50% after *deductible* | Includes autistic disease, mental retardation, *developmental delays*, and learning disabilities. |
| Inpatient | 70% after *deductible* | 50% after *deductible* | Includes detox and residential treatment.<br>***Pre-certification* is required.** |
| Outpatient | 70% after *deductible* | 50% after *deductible* | Includes intensive outpatient therapy, *partial hospitalization*, and online visits.<br>***Pre-certification* is required for transcranial magnetic stimulation, intensive outpatient therapy, and partial hospitalization.** |
| **Nutritional Counseling** | 70% after *deductible* | 50% after *deductible* | When *medically necessary* for diabetes, home health care, or hospice. |
| **Obesity Services** | 70% after *deductible* | 50% after *deductible* | ***Pre-certification* is required for surgical services.** |
| **Office/Home Visits** | 70% after *deductible* | 50% after *deductible* | |
| **Online Visits** | 70% after *deductible* | Not Covered | Online visits through LiveHealth Online. Refer to Quick Reference Information Chart for contact information. |
| **Orthotics/Prosthetics** | 70% after *deductible* | 50% after *deductible* | |
| **Outpatient Observation Stays** | 70% after *deductible* | 50% after *deductible* | After twenty-four (24) observation hours, a confinement will be considered at this benefit level. Prior to twenty-four (24) observation hours, benefits will pay at the applicable benefit level. |
| **Outpatient Professional Services** | 70% after *deductible* | 50% after *deductible* | |
| **Outpatient Surgery** | 70% after *deductible* | 50% after *deductible* | ***Pre-certification* is required for *outpatient surgical procedures*** (excluding *outpatient* office *surgical procedures*). |
| **Routine Newborn Care** | 70% after *deductible* | 50% after *deductible* | Routine newborn care is subject to the mother's *deductible* and *out-of-pocket limit*. If the mother is not covered under the *Plan*, then these expenses apply to the covered *employee's deductible* and *out-of-pocket limit*. |
| **Skilled Nursing Facility/ Extended Care** | 70% after *deductible* | 50% after *deductible* | **Calendar Year Maximum:** Sixty (60) days per *plan participant*, *network* and *non-network* combined.<br>Long term acute care and rehabilitation hospital services apply toward this maximum.<br>***Pre-certification* is required.** |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Temporomandibular Joint Syndrome (TMJ)** | 70% after *deductible* | 50% after *deductible* | ***Pre-certification* is required for surgical services.** |
| **Therapy Services, Outpatient** | | | |
| Physical Therapy<br>Occupational Therapy<br>Speech Therapy<br>Cognitive Therapy<br>Vision Therapy | 70% after *deductible* | 50% after *deductible* | **Calendar Year Maximum:** Sixty (60) visits per *plan participant* for physical, speech, occupational, cognitive, and vision therapies combined, unless *medical necessity* requires additional visits. Maximum includes habilitative services.<br>Therapy services apply to the rendering provider benefit maximum. |
| Cardiac Rehabilitation<br>Pulmonary Rehabilitation | 70% after *deductible* | 50% after *deductible* | |
| **Urgent Care** | 70% after *deductible* | 50% after *deductible* | Includes retail health clinics. |
| **Vision Care** | 70% after *deductible* | 50% after *deductible* | Medical vision exam. Does not include routine vision exams or prescription lenses. |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **PREVENTIVE CARE**<br><br>If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network* provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites:<br><br>**https://www.healthcare.gov/coverage/preventive-care-benefits/**<br>**http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**<br>**www.hrsa.gov**<br><br>Non-Preventive Care services which are ordered or performed at a Routine Wellness Care visit are not considered under the Preventive Care benefit. Those services will apply to their applicable benefit level or exclusion as appropriate. | | | |
| **Routine Wellness Care** | 100%,<br>*deductible* waived | 100%,<br>*deductible* waived | Services include routine physical exam, immunizations, gynecological exam, pap smear, PSA test, 2D and 3D mammogram, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. |
| **Breastfeeding Pump and Supplies** | 100%,<br>*deductible* waived | 100%,<br>*deductible* waived | Breastfeeding support, supplies, and counseling. Breast pumps are limited to one (1) per pregnancy and a maximum of $500. ***Pre-certification* is required** for breast pumps exceeding $500 purchase price. |
| **Contraceptive Services** | 100%,<br>*deductible* waived | 100%,<br>*deductible* waived | Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion.<br><br>**Benefit Limitations:** Services are available to all female *plan participants*. |
| **TRANSPLANTS** | | | |
| Organ Transplants<br>Live Donor Health Services | 100% after<br>*deductible* | 80% after<br>*deductible* | Not Covered | Refer to the **Transplant Program** section for a further description and limitations of this benefit.<br><br>All other related services will pay under the applicable benefit level.<br><br>***Pre-certification* is required.** |
| Bone Marrow Donor Search Fee | 100% after<br>*deductible* | 80% after<br>*deductible* | Not Covered | Limited to $30,000 per transplant. |

**Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.**

**M. Schedule of Prescription Drug Benefits –HSA Blue and Green Plan Options**

The *prescription drug* benefits are separate from the medical benefits and are administered by Navitus. Refer to the **Prescription Drug Benefits** section of this summary plan description for additional information on *prescription drug* coverage.

*Prescription drug* charges apply to the medical *deductible* and *out-of-pocket maximum*.

Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

| | NETWORK | NON-NETWORK |
|---|---|---|
| **Retail Pharmacy Option (30-Day Supply)** | | |
| Tier 1: Preferred Generic Drugs | 80% after *deductible* | Not Covered |
| Tier 2: Preferred Brand and Non-Preferred Generic Drugs | 75% after *deductible* | Not Covered |
| Tier 3: Non-Preferred Brand Name Drugs | 70% after *deductible* | Not Covered |
| Specialty Drugs | 70% after *deductible* | Not Covered |
| **Mail Order Pharmacy Option (90-Day Supply)** | | |
| Preferred Generic Drugs | 80% after *deductible* | Not Applicable |
| Preferred Brand and Non-Preferred Generic Drugs | 75% after *deductible* | Not Applicable |
| Non-Preferred Brand Name Drugs | 70% after *deductible* | Not Applicable |
| *Plan participants* are encouraged to use the Mail Order Pharmacy. There is an additional $20 surcharge beginning with the third fill of maintenance medication obtained at a Retail Pharmacy.<br><br>Certain diabetic and asthmatic supplies are covered subject to applicable *prescription drug* benefits when obtained from a *network* pharmacy. These supplies are covered as medical supplies and durable medical equipment if obtained from a *non-network* pharmacy. Diabetic test strips are covered subject to applicable *prescription drug co-insurance*.<br><br>For specialty medications, your first fill may be obtained at a retail pharmacy but refills must come from the Worthington Industries Pharmacy or Lumicera, Navitus' Specialty Pharmacy.<br><br>Your *deductible* and *co-insurance* amounts will not be reduced by any discounts, rebates, or other funds received by Navitus and/or the *Plan* from drug manufacturers or similar vendors. For *covered charges* provided by a *network* pharmacy or mail order pharmacy, you are responsible for all *deductible* and *co-insurance* amounts. | | |
| Certain *preventive care prescription drugs* (including generic and brand contraceptives without a generic alternative) received by a *network pharmacy* are covered at 100% and the *deductible/co-insurance* (if applicable) is waived.<br><br>Please refer to the following websites for information on the types of payable *preventive care prescription drugs*: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**. | | |

*Claims* for *non-network* reimbursement of *prescription drugs* are to be submitted to Navitus at:

Navitus Health Solutions
ATTN: Commercial Claims
P.O. Box 999
Appleton, WI 54912-0999

**NOTE:** For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the Navitus Drug Coverage List, which is incorporated by reference and is available from your *employer* or MyQHealth Care Coordinators at 1.888.971.7377 or **https://client.formularynavigator.com/Search.aspx?siteCode=2055289521.**

## N. Schedule of Medical Benefits –HRA Blue Plan Option

| | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|
| **Deductible, per Calendar Year**<br>The *network* and *non-network deductible* amounts accumulate towards each other. | | |
| Employee Only | $1,500 | |
| Family | $3,000 | |
| **Family Unit - Non-Embedded Deductible**<br>If you are enrolled in family coverage, there is not an individual *deductible* embedded in the *family* coverage *deductible*. Before your *Plan* helps you pay for any of your medical bills, the entire amount of the *family* coverage *deductible* must be met first. It can be met by one (1) family member or a combination of family members; however, there are no benefits (except for *preventive care*) until expenses equaling the *family* coverage *deductible* amount have been *incurred*.<br>**For example,** if you, your spouse, and child are on a family plan with a $3,000 *family* coverage non-embedded *deductible* and the individual *deductible* is $1,500, and your child *incurs* $1,500 in medical bills, your *Plan* will NOT help pay subsequent medical bills until the *family* coverage *deductible* of $3,000 has been met yet. | | |
| **Maximum Out-of-Pocket Limit, per Calendar Year**<br>The *out-of-pocket limit* includes *co-insurance*, *deductibles,* and covered *prescription drug* charges.<br>The *network* and *non-network out-of-pocket limits* accumulate towards each other. *Prescription drug* charges accumulate toward both the *network* and *non-network out-of-pocket limit*. | | |
| Employee Only | $3,500 | $5,000 |
| Family | $7,000 | $10,000 |
| **Family Unit - Non-Embedded Out-of-Pocket Limit**<br>If you are enrolled in *family* coverage, there is not an individual *out-of-pocket limit* embedded in the *family* coverage *out-of-pocket limit*. Before your *covered charges* are payable at 100% (except for the charges excluded), the entire amount of the *family* coverage *out-of-pocket limit* must be met first. It can be met by one (1) family member or a combination of family members. When a *family* reaches the *out-of-pocket limit*, *covered charges* for that *family* will be payable at 100% (except for the charges excluded) for the remainder of the *calendar year*. | | |
| The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached, at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise.<br>**NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the *Plan*:**<br>1. cost containment penalties<br>2. amounts over *the maximum allowable charges*<br>3. charges not covered under the *Plan*<br>4. *balanced billed* charges<br>5. charges for services that are not *medically necessary* | | |

Benefits are shown as the percentage the *Plan* will pay.

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **General Percentage Payment Rule** | 80% after *deductible* | 60% after *deductible* | Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply. |
| **Acupuncture** | 80% after *deductible* | | **Calendar Year Maximum:** Twenty (20) visits per *plan participant*. |
| **Advanced Imaging** | 80% after *deductible* | 60% after *deductible* | Includes: 3D mammograms, Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, SPECT scans, and PET scans, excluding services rendered in an emergency room setting.<br>***Pre-certification* is required for MRI/MRA and PET scans.** |
| **Allergy Services** | | | |
| Allergy Testing | 80% after *deductible* | 60% after *deductible* | |
| Allergy Treatment | 80% after *deductible* | 60% after *deductible* | |
| **Ambulance Service** | 80% after *deductible* | | Air ambulance will suspend for *medical necessity*. |
| **Chemotherapy Drugs/Infusions and Radiation Treatments** | 80% after *deductible* | 60% after *deductible* | This benefit applies for all covered *medically necessary* diagnoses.<br>***Pre-certification* is required.** |
| **Chiropractic Treatment** | 80% after *deductible* | 60% after *deductible* | **Calendar Year Maximum:** Twenty (20) visits per *plan participant*, *network* and *non-network* combined. Spinal manipulations apply to the rendering provider benefit maximum. |
| **Clinical Trials** | 80% after *deductible* | 60% after *deductible* | Refer to **Medical Benefits** section for details. |
| **Consultation/Second Surgical Opinion** | 80% after *deductible* | 60% after *deductible* | |
| **Dental Injury and Oral Surgery** | 80% after *deductible* | 60% after *deductible* | |
| **Diagnostic Testing, Lab, and X-Ray** | 80% after *deductible* | 60% after *deductible* | |
| **Durable Medical Equipment (DME)** | | | |
| Durable Medical Equipment | 80% after *deductible* | | ***Pre-certification* is required for all rentals and any purchase in excess of $1,500.** |
| Diabetic Equipment | 80% after *deductible* | | |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Emergency Room** | 80% after *deductible* | | Emergency room professional fees will be based on the *maximum allowable charges*. |
| **Hearing** | 80% after *deductible* | 60% after *deductible* | Includes surgically implanted hearing aid devices and non-routine medical hearing care. |
| **Home Health Care** | 80% after *deductible* | 60% after *deductible* | Includes home infusion therapy.<br>***Pre-certification* is required.** |
| **Hospice Care** | | | |
| Hospice Care | 100% after *deductible* | 100% after *deductible* | *Hospice care services and supplies* for *plan participants* with a life expectancy of less than twelve (12) months.<br>***Pre-certification* is required.** |
| Bereavement Counseling | | | Counseling for covered family members limited to one (1) year after a *plan participant's* death. |
| **Injections and Infusion Therapy** | 80% after *deductible* | 60% after *deductible* | Benefits are available for injections and infusion therapies received in an office setting or other covered facility. |
| **Inpatient Hospital** | | | |
| Physician Visits | 80% after *deductible* | 60% after *deductible* | |
| Room and Board | 80% after *deductible* | 60% after *deductible* | Limited to the semi-private room rate when such semi-private room rate is available.<br>***Pre-certification* is required.** |
| **Maternity and Reproductive Care** | | | |
| Initial Office Visit | 80% after *deductible* | 60% after *deductible* | *Dependent* child *pregnancy* is covered.<br>Includes coverage for therapeutic abortions, contraceptives not covered under preventive care, diagnostic testing and treatment for infertility, and sterilization services, including vasectomy.<br>All other *covered charges* billed by the *physician* for maternity care.<br>***Pre-certification* is required** for inpatient procedures, surgical services, and maternity or newborn stays exceeding forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean section. |
| All Other Services | 80% after *deductible* | 60% after *deductible* | |
| Labor and Delivery | 80% after *deductible* | 60% after *deductible* | |
| **Medical Supplies** | 80% after *deductible* | | |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Mental Disorders & Substance Use Disorder** | | | |
| ADD/ADHD | 80% after *deductible* | 60% after *deductible* | Includes autistic disease, mental retardation, *developmental delays*, and learning disabilities. |
| Inpatient | 80% after *deductible* | 60% after *deductible* | Includes detox and residential treatment.<br>***Pre-certification* is required.** |
| Outpatient | 80% after *deductible* | 60% after *deductible* | Includes intensive outpatient therapy, *partial hospitalization*, and online visits.<br>***Pre-certification* is required for intensive outpatient therapy and partial hospitalization.** |
| **Nutritional Counseling** | 80% after *deductible* | 60% after *deductible* | When *medically necessary* for diabetes, home health care, or hospice. |
| **Obesity Services** | 80% after *deductible* | 60% after *deductible* | ***Pre-certification* is required for surgical services.** |
| **Office/Home Visits** | 80% after *deductible* | 60% after *deductible* | |
| **Online Visits** | 80% after *deductible* | Not Covered | Online visits through LiveHealth Online. Refer to Quick Reference Information Chart for contact information. |
| **Orthotics/Prosthetics** | 80% after *deductible* | 60% after *deductible* | |
| **Outpatient Observation Stays** | 80% after *deductible* | 60% after *deductible* | After twenty-four (24) observation hours, a confinement will be considered at this benefit level. Prior to twenty-four (24) observation hours, benefits will pay at the applicable benefit level. |
| **Outpatient Professional Services** | 80% after *deductible* | 60% after *deductible* | |
| **Outpatient Surgery** | 80% after *deductible* | 60% after *deductible* | ***Pre-certification* is required for *outpatient surgical procedures*** (excluding *outpatient* office *surgical procedures*). |
| **Routine Newborn Care** | 80% after *deductible* | 60% after *deductible* | Routine newborn care is subject to the mother's *deductible* and *out-of-pocket limit*. If the mother is not covered under the *Plan*, then these expenses apply to the covered *employee's deductible* and *out-of-pocket limit*. |
| **Skilled Nursing Facility/ Extended Care** | 80% after *deductible* | 60% after *deductible* | **Calendar Year Maximum:** Sixty (60) days per *plan participant*, *network* and *non-network* combined.<br>Long term acute care and rehabilitation hospital services apply toward this maximum.<br>***Pre-certification* is required.** |
| **Temporomandibular Joint Syndrome (TMJ)** | 80% after *deductible* | 60% after *deductible* | ***Pre-certification* is required for surgical services.** |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Therapy Services, Outpatient** | | | |
| Physical Therapy<br>Occupational Therapy<br>Speech Therapy<br>Cognitive Therapy<br>Vision Therapy | 80% after *deductible* | 60% after *deductible* | **Calendar Year Maximum:** Sixty (60) visits per *plan participant* for physical, speech, occupational, cognitive, and vision therapies combined, unless *medical necessity* requires additional visits. Maximum includes habilitative services.<br>Therapy services apply to the rendering provider benefit maximum. |
| Cardiac Rehabilitation<br>Pulmonary Rehabilitation | 80% after *deductible* | 60% after *deductible* | |
| **Urgent Care** | 80% after *deductible* | 60% after *deductible* | Includes retail health clinics. |
| **Vision Care** | 80% after *deductible* | 60% after *deductible* | Medical vision exam. Does not include routine vision exams or prescription lenses. |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **PREVENTIVE CARE**<br><br>If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network* provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites:<br><br>**https://www.healthcare.gov/coverage/preventive-care-benefits/**<br>**http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**<br>**www.hrsa.gov**<br><br>Non-Preventive Care services which are ordered or performed at a Routine Wellness Care visit are not considered under the Preventive Care benefit. Those services will apply to their applicable benefit level or exclusion as appropriate. | | | |
| **Routine Wellness Care** | 100%,<br>*deductible* waived | 100%,<br>*deductible* waived | Services include routine physical exam, immunizations, gynecological exam, pap smear, PSA test, 2D and 3D mammogram, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. |
| **Breastfeeding Pump and Supplies** | 100%,<br>*deductible* waived | 100%,<br>*deductible* waived | Breastfeeding support, supplies, and counseling. Breast pumps are limited to one (1) per pregnancy and a maximum of $500. ***Pre-certification* is required** for breast pumps exceeding $500 purchase price. |
| **Contraceptive Services** | 100%,<br>*deductible* waived | 100%,<br>*deductible* waived | Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion.<br><br>**Benefit Limitations:** Services are available to all female *plan participants*. |
| **TRANSPLANTS** | | | |
| Organ Transplants<br>Live Donor Health Services | 100% after *deductible* | 80% after *deductible* | Refer to the **Transplant Program** section for a further description and limitations of this benefit.<br><br>All other related services will pay under the applicable benefit level.<br><br>***Pre-certification* is required.** |
| Bone Marrow Donor Search Fee | 100% after *deductible* | 80% after *deductible* | Limited to $30,000 per transplant. |

**Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.**

## O. Schedule of Medical Benefits –HRA Green Plan Option

| | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|
| **Deductible, per Calendar Year**<br>The *network* and *non-network deductible* amounts accumulate towards each other. | | |
| Employee Only | $2,500 | |
| Family | $5,000 | |
| **Family Unit - Non-Embedded Deductible**<br>If you are enrolled in family coverage, there is not an individual *deductible* embedded in the *family* coverage *deductible*. Before your *Plan* helps you pay for any of your medical bills, the entire amount of the *family* coverage *deductible* must be met first. It can be met by one (1) family member or a combination of family members; however, there are no benefits (except for *preventive care*) until expenses equaling the *family* coverage *deductible* amount have been *incurred*.<br>**For example,** if you, your spouse, and child are on a family plan with a $3,000 *family* coverage non-embedded *deductible* and the individual *deductible* is $1,500, and your child *incurs* $1,500 in medical bills, your *Plan* will NOT help pay subsequent medical bills until the *family* coverage *deductible* of $3,000 has been met yet. | | |
| **Maximum Out-of-Pocket Limit, per Calendar Year**<br>The *out-of-pocket limit* includes *co-insurance*, *deductibles,* and covered *prescription drug* charges.<br>The *network* and *non-network out-of-pocket limits* accumulate towards each other. *Prescription drug* charges accumulate toward both the *network* and *non-network out-of-pocket limit*. | | |
| Employee Only | $4,500 | $6,000 |
| Family | $9,000 | $12,000 |
| **Family Unit - Non-Embedded Out-of-Pocket Limit**<br>If you are enrolled in *family* coverage, there is not an individual *out-of-pocket limit* embedded in the *family* coverage *out-of-pocket limit*. Before your *covered charges* are payable at 100% (except for the charges excluded), the entire amount of the *family* coverage *out-of-pocket limit* must be met first. It can be met by one (1) family member or a combination of family members. When a *family* reaches the *out-of-pocket limit*, *covered charges* for that *family* will be payable at 100% (except for the charges excluded) for the remainder of the *calendar year*. | | |
| The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached, at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise.<br>**NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the *Plan*:**<br>1. cost containment penalties<br>2. amounts over *the maximum allowable charges*<br>3. charges not covered under the *Plan*<br>4. *balanced billed* charges<br>5. charges for services that are not *medically necessary* | | |

Benefits are shown as the percentage the *Plan* will pay.

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **General Percentage Payment Rule** | 70% after *deductible* | 50% after *deductible* | Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply. |
| **Acupuncture** | 70% after *deductible* | | **Calendar Year Maximum:** Twenty (20) visits per *plan participant*. |
| **Advanced Imaging** | 70% after *deductible* | 50% after *deductible* | Includes: 3D mammograms, Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, SPECT scans, and PET scans, excluding services rendered in an emergency room setting.<br>***Pre-certification* is required for MRI/MRA and PET scans.** |
| **Allergy Services** | | | |
| Allergy Testing | 70% after *deductible* | 50% after *deductible* | |
| Allergy Treatment | 70% after *deductible* | 50% after *deductible* | |
| **Ambulance Service** | 70% after *deductible* | | Air ambulance will suspend for *medical necessity*. |
| **Chemotherapy Drugs/Infusions and Radiation Treatments** | 70% after *deductible* | 50% after *deductible* | This benefit applies for all covered *medically necessary* diagnoses.<br>***Pre-certification* is required.** |
| **Chiropractic Treatment** | 70% after *deductible* | 50% after *deductible* | **Calendar Year Maximum:** Twenty (20) visits per *plan participant*, *network* and *non-network* combined. Spinal manipulations apply to the rendering provider benefit maximum. |
| **Clinical Trials** | 70% after *deductible* | 50% after *deductible* | Refer to **Medical Benefits** section for details. |
| **Consultation/Second Surgical Opinion** | 70% after *deductible* | 50% after *deductible* | |
| **Dental Injury and Oral Surgery** | 70% after *deductible* | 50% after *deductible* | |
| **Diagnostic Testing, Lab, and X-Ray** | 70% after *deductible* | 50% after *deductible* | |
| **Durable Medical Equipment (DME)** | | | |
| Durable Medical Equipment | 70% after *deductible* | | ***Pre-certification* is required for all rentals and any purchase in excess of $1,500.** |
| Diabetic Equipment | 70% after *deductible* | | |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Emergency Room** | 70% after *deductible* | | Emergency room professional fees will be based on the *maximum allowable charges*. |
| **Hearing** | 70% after *deductible* | 50% after *deductible* | Includes surgically implanted hearing aid devices and non-routine medical hearing care. |
| **Home Health Care** | 70% after *deductible* | 50% after *deductible* | Includes home infusion therapy.<br>***Pre-certification* is required.** |
| **Hospice Care** | | | |
| Hospice Care | 100% after *deductible* | 100% after *deductible* | *Hospice care services and supplies* for *plan participants* with a life expectancy of less than twelve (12) months.<br>***Pre-certification* is required.** |
| Bereavement Counseling | | | Counseling for covered family members limited to one (1) year after a *plan participant's* death. |
| **Injections and Infusion Therapy** | 70% after *deductible* | 50% after *deductible* | Benefits are available for injections and infusion therapies received in an office setting or other covered facility. |
| **Inpatient Hospital** | | | |
| Physician Visits | 70% after *deductible* | 50% after *deductible* | |
| Room and Board | 70% after *deductible* | 50% after *deductible* | Limited to the semi-private room rate when such semi-private room rate is available.<br>***Pre-certification* is required.** |
| **Maternity and Reproductive Care** | | | |
| Initial Office Visit | 70% after *deductible* | 50% after *deductible* | *Dependent* child *pregnancy* is covered.<br>Includes coverage for therapeutic abortions, contraceptives not covered under preventive care, diagnostic testing and treatment for infertility, and sterilization services, including vasectomy.<br>All other *covered charges* billed by the *physician* for maternity care.<br>***Pre-certification* is required** for inpatient procedures, surgical services, and maternity or newborn stays exceeding forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean section. |
| All Other Services | 70% after *deductible* | 50% after *deductible* | |
| Labor and Delivery | 70% after *deductible* | 50% after *deductible* | |
| **Medical Supplies** | 70% after *deductible* | | |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Mental Disorders & Substance Use Disorder** | | | |
| ADD/ADHD | 70% after *deductible* | 50% after *deductible* | Includes autistic disease, mental retardation, *developmental delays*, and learning disabilities. |
| Inpatient | 70% after *deductible* | 50% after *deductible* | Includes detox and residential treatment.<br>***Pre-certification* is required.** |
| Outpatient | 70% after *deductible* | 50% after *deductible* | Includes intensive outpatient therapy, *partial hospitalization*, and online visits.<br>***Pre-certification* is required for intensive outpatient therapy and partial hospitalization.** |
| **Nutritional Counseling** | 70% after *deductible* | 50% after *deductible* | When *medically necessary* for diabetes, home health care, or hospice. |
| **Obesity Services** | 70% after *deductible* | 50% after *deductible* | ***Pre-certification* is required for surgical services.** |
| **Office/Home Visits** | 70% after *deductible* | 50% after *deductible* | |
| **Online Visits** | 70% after *deductible* | Not Covered | Online visits through LiveHealth Online. Refer to Quick Reference Information Chart for contact information. |
| **Orthotics/Prosthetics** | 70% after *deductible* | 50% after *deductible* | |
| **Outpatient Observation Stays** | 70% after *deductible* | 50% after *deductible* | After twenty-four (24) observation hours, a confinement will be considered at this benefit level. Prior to twenty-four (24) observation hours, benefits will pay at the applicable benefit level. |
| **Outpatient Professional Services** | 70% after *deductible* | 50% after *deductible* | |
| **Outpatient Surgery** | 70% after *deductible* | 50% after *deductible* | ***Pre-certification* is required for *outpatient surgical procedures*** (excluding *outpatient* office *surgical procedures*). |
| **Routine Newborn Care** | 70% after *deductible* | 50% after *deductible* | Routine newborn care is subject to the mother's *deductible* and *out-of-pocket limit*. If the mother is not covered under the *Plan*, then these expenses apply to the covered *employee's deductible* and *out-of-pocket limit*. |
| **Skilled Nursing Facility/ Extended Care** | 70% after *deductible* | 50% after *deductible* | **Calendar Year Maximum:** Sixty (60) days per *plan participant*, *network* and *non-network* combined.<br>Long term acute care and rehabilitation hospital services apply toward this maximum.<br>***Pre-certification* is required.** |
| **Temporomandibular Joint Syndrome (TMJ)** | 70% after *deductible* | 50% after *deductible* | ***Pre-certification* is required for surgical services.** |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **Therapy Services, Outpatient** | | | |
| Physical Therapy<br>Occupational Therapy<br>Speech Therapy<br>Cognitive Therapy<br>Vision Therapy | 70% after *deductible* | 50% after *deductible* | **Calendar Year Maximum:** Sixty (60) visits per *plan participant* for physical, speech, occupational, cognitive, and vision therapies combined, unless *medical necessity* requires additional visits. Maximum includes habilitative services.<br>Therapy services apply to the rendering provider benefit maximum. |
| Cardiac Rehabilitation<br>Pulmonary Rehabilitation | 70% after *deductible* | 50% after *deductible* | |
| **Urgent Care** | 70% after *deductible* | 50% after *deductible* | Includes retail health clinics. |
| **Vision Care** | 70% after *deductible* | 50% after *deductible* | Medical vision exam. Does not include routine vision exams or prescription lenses. |

| COVERED SERVICES | NETWORK PROVIDERS | NON-NETWORK PROVIDERS | SPECIAL COMMENTS |
|---|---|---|---|
| **PREVENTIVE CARE**<br><br>If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network* provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites:<br><br>**https://www.healthcare.gov/coverage/preventive-care-benefits/**<br>**http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**<br>**www.hrsa.gov**<br><br>Non-Preventive Care services which are ordered or performed at a Routine Wellness Care visit are not considered under the Preventive Care benefit. Those services will apply to their applicable benefit level or exclusion as appropriate. | | | |
| **Routine Wellness Care** | 100%, *deductible* waived | 100%, *deductible* waived | Services include routine physical exam, immunizations, gynecological exam, pap smear, PSA test, 2D and 3D mammogram, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. |
| **Breastfeeding Pump and Supplies** | 100%, *deductible* waived | 100%, *deductible* waived | Breastfeeding support, supplies, and counseling. Breast pumps are limited to one (1) per pregnancy and a maximum of $500. ***Pre-certification* is required** for breast pumps exceeding $500 purchase price. |
| **Contraceptive Services** | 100%, *deductible* waived | 100%, *deductible* waived | Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion.<br><br>**Benefit Limitations:** Services are available to all female *plan participants*. |
| **TRANSPLANTS** | | | |
| Organ Transplants<br>Live Donor Health Services | 100% after *deductible* | 80% after *deductible* | Not Covered | Refer to the **Transplant Program** section for a further description and limitations of this benefit.<br><br>All other related services will pay under the applicable benefit level.<br><br>***Pre-certification* is required.** |
| Bone Marrow Donor Search Fee | 100% after *deductible* | 80% after *deductible* | Not Covered | Limited to $30,000 per transplant. |

**Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.**

**P. Schedule of Prescription Drug Benefits – HRA Blue and Green Plan Options**

The *prescription drug* benefits are separate from the medical benefits and are administered by Navitus. Refer to the **Prescription Drug Benefits** section of this summary plan description for additional information on *prescription drug* coverage.

*Prescription drug* charges apply to the medical *deductible* and *out-of-pocket maximum*.

Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

| | NETWORK | NON-NETWORK |
|---|---|---|
| **Retail Pharmacy Option (30 Day Supply)** | | |
| Tier 1: Preferred Generic Drugs | 80% after *deductible* | Not Covered |
| Tier 2: Preferred Brand and Non-Preferred Generic Drugs | 75% after *deductible* | Not Covered |
| Tier 3: Non-Preferred Brand Name Drugs | 70% after *deductible* | Not Covered |
| Specialty Drugs | 70% after *deductible* | Not Covered |
| **Mail Order Pharmacy Option (90 Day Supply)** | | |
| Preferred Generic Drugs | 80% after *deductible* | Not Applicable |
| Preferred Brand and Non-Preferred Generic Drugs | 75% after *deductible* | Not Applicable |
| Non-Preferred Brand Name Drugs | 70% after *deductible* | Not Applicable |
| *Plan participants* are encouraged to use the Mail Order Pharmacy. There is an additional $20 surcharge beginning with the third fill of maintenance medication obtained at a Retail Pharmacy.<br><br>Certain diabetic and asthmatic supplies are covered subject to applicable *prescription drug* benefits when obtained from a *network* pharmacy. These supplies are covered as medical supplies and durable medical equipment if obtained from a *non-network* pharmacy. Diabetic test strips are covered subject to applicable *prescription drug co-insurance*.<br><br>For specialty medications, your first fill may be obtained at a retail pharmacy but refills must come from the Worthington Industries Pharmacy or Lumicera, Navitus' Specialty Pharmacy.<br><br>Your *deductible* and *co-insurance* amounts will not be reduced by any discounts, rebates, or other funds received by Navitus and/or the *Plan* from drug manufacturers or similar vendors. For *covered charges* provided by a *network* pharmacy or mail order pharmacy, you are responsible for all *deductible* and *co-insurance* amounts. | | |
| Certain *preventive care prescription drugs* (including generic and brand contraceptives without a generic alternative) received by a *network pharmacy* are covered at 100% and the *deductible/co-insurance* (if applicable) is waived.<br><br>Please refer to the following websites for information on the types of payable *preventive care prescription drugs*: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**. | | |

*Claims* for *non-network* reimbursement of *prescription drugs* are to be submitted to Navitus using the Prescription Drug Claims Form and mailed to:

Navitus Health Solutions
ATTN: Commercial Claims
P.O. Box 999
Appleton, WI 54912-0999

**NOTE:** For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the Navitus Drug Coverage List, which is incorporated by reference and is available from your *employer* or MyQHealth Care Coordinators at 1.888.971.7377 or **https://client.formularynavigator.com/Search.aspx?siteCode=2055289521.**

## Q. Schedule of Outpatient Dialysis Services

The *outpatient* dialysis benefits are separate from the medical benefits and are administered by AmeriBen. Refer to the **Outpatient Dialysis Services** section of this plan document for additional information on *outpatient* dialysis services coverage.

| COVERED SERVICES | ALL PROVIDERS | SPECIAL COMMENTS |
|---|---|---|
| **DIALYSIS, OUTPATIENT** | | |
| **Dialysis, Outpatient Charges** | 80% after *deductible* | The following *outpatient dialysis* services will be considered at 125% of *Medicare*, and then *Plan* benefits will apply.<br>• facility and professional charges from *outpatient hospitals* and dialysis facilities<br>• home dialysis charges<br>Refer to the **Outpatient Dialysis Services** section for a further description and limitations of this benefit.<br>***Pre-certification* is required.** |

# SECTION VI—MEDICAL BENEFITS

Medical Benefits apply when *covered charges* are *incurred* for care of an *injury* or *illness* while a *plan participant* is covered for these benefits under the *Plan*.

### A. Covered Medical Charges

*Covered charges* are the *maximum allowable charges* that are *incurred* for the following items of service and supply. These charges are subject to the benefit limits, exclusions, and other provisions of this *Plan*. A charge is *incurred* on the date that the service or supply is performed or furnished.

1. **3D Mammograms.** Covered as preventive and diagnostic services.
2. **Accidental Injuries.** Services and supplies to treat *accidental injuries*. All *outpatient surgical procedures* related to the treatment of an *accidental injury*, when provided in a *physician's* office, will be covered under the member's *physician's* office benefit.
3. **Acupuncture.** Expenses *incurred* for acupuncture administered by a *physician* licensed for this treatment. Includes acupuncture services to relieve chronic pain or nausea related to chemotherapy or pregnancy. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
4. **ADD/ADHD.** Medical treatment for Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD). Includes autistic disease, mental retardation, *developmental delays*, and learning disabilities. Educational services are not covered.
5. **Adoptive Cell Therapy. *Pre-certification* is required.** Refer to the Travel Expenses provisions in the **Medical Benefits** section for more information on travel benefits available for services rendered at a *Center of Excellence*.
6. **Advanced Imaging.** Charges for advanced imaging including: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans. Charges include the readings of these medical tests/scans. ***Pre-certification* is required for MRI/MRA and PET scans.**
7. **Allergy Services.** Charges for allergy testing and the cost of the resultant serum preparation (antigen) and its administration, when rendered by a *physician*, or in the *physician's* office.
8. **Ambulance.** Benefits will be provided for licensed ground, air, and water ambulance services used to transport you from the place where you are *injured* or stricken by *illness*, or for inter-facility transport, as deemed *medically necessary* or to move you from a *non-network* facility to a *network* facility, to the nearest accredited general *hospital* with adequate facilities for treatment. Inter-facility transport is also available to a *network hospital* after you have been stabilized at a *non-network hospital*. In certain cases the *Claims Administrator* may approve benefits for transportation to a facility that is not the nearest facility. Charges for medically necessary treatment of an illness or injury rendered by medical professionals from an ambulance service, even when the patient is not transported, will be covered by the *Plan*.

   Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach. Air ambulance will not be covered if you are taken to a *hospital* that is not an acute care *hospital* (such as a *skilled nursing facility*), or if you are taken to a *physician's* office or your home.

   If you are moving from one *hospital* to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the *hospital* that first treats cannot give you the medical services you need. To be covered, you must be taken to the closest *hospital* that can treat you. Coverage is not available for air ambulance transfers simply because you, your family, or your provider prefers a specific *hospital* or *physician*. When using an air ambulance, for non-emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider.
9. **Anesthetics.** Includes anesthetic, oxygen, intravenous injections/solutions, and the administration of these items. Includes spinal or regional anesthesia and injection inhalation of a drug or other agent. Local infiltration is excluded. Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.
10. **Applied Behavior Analysis (ABA) Therapy.** Benefits will be paid the same as any other *illness* for *covered charges* related to the assessment, diagnosis, and treatment. Treatment must be prescribed or ordered by a licensed *physician* or licensed psychologist. *Applied behavior analysis* is covered when *medically necessary*, appropriate, effective, or efficient. ***Pre-certification* is required.**
11. **Blood.** Non-replaced blood, blood plasma, blood derivatives, and their administration and processing.

12. **Cardiac Rehabilitation.** Cardiac rehabilitation as deemed *medically necessary,* provided services are:
    a. initiated within twelve (12) weeks after other treatment for the medical condition ends
    b. rendered in a *medical care facility* as defined by this *Plan*
13. **Chemotherapy/Radiation.** Radiation or chemotherapy and treatment with radioactive substances, including materials and services of technicians. ***Pre-certification* is required.**
14. **Chiropractic.** Includes all *medically necessary* services. *Spinal manipulations* apply to the rendering provider's benefit maximum.
15. **Circumcision.** Circumcision for newborns from birth to six (6) months. After six (6) months, only *medically necessary* circumcisions will be covered.
16. **Clinical Trials.** This *Plan* will cover routine patient costs for a *qualified individual* participating in an *approved clinical trial* that is conducted in connection with the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an *investigational* new drug application reviewed by the Food and Drug Administration, or is exempt from *investigational* new drug application requirements. Refer to the Medical Plan Exclusions subsection for a further description and limitations of this benefit.
17. **Contraceptives.** Injections, implants, devices, and associated *physician* charges are covered under the Preventive Care provision and/or the Maternity and Reproductive Care provisions of this *Plan*.
18. **Consultation Services.** Covered when the special skill and knowledge of a consulting *physician* is required for the diagnosis or treatment of an *illness* or *injury*. Second surgical opinion consultations are covered.
19. **Dental Injuries.** *Accidental injury* to or care of the mouth, teeth, gums, and alveolar processes will be *covered charges* under this *Plan* only if that care is initiated within twelve (12) months following the injury and is for the following oral *surgical procedures*:
    a. *emergency* repair due to *injury* to *sound natural teeth*
    b. initial repair needed to correct *accidental injuries* to the jaws, cheeks, lips, tongue, floor, and roof of the mouth

    *Injury* as a result of chewing or biting is not considered an *accidental injury* except where the chewing or biting results from an act of domestic violence or directly from a medical condition. No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease*, and preparing the mouth for fitting of or continued use of dentures.
20. **Diabetic Education.** Services and supplies used in *outpatient* diabetes self-management programs are covered under this *Plan* when they are provided by a *physician*. Includes nutritional therapy.
21. **Diabetic Equipment.** Insulin pumps, continuous glucose monitors, and related supplies will be covered when *medically necessary*, under the *durable medical equipment* (*DME*) provision of this *Plan*.

    For all other diabetic supplies coverage, including lancets, syringes, and insulin, refer to the **Prescription Drugs Benefits** section. Diabetic supplies not covered under the pharmacy benefit are covered by the medical plan.
22. **Diagnostic Testing.**
23. **Durable Medical Equipment (DME).** Rental of *durable medical equipment* (*DME*) if deemed *medically necessary*. The total rental fee for *durable medical equipment* will not exceed the purchase price of the equipment. If the purchase price is not available, rental is allowed for the lifetime of the equipment. Delivery or set-up charges are not a benefit of the *Plan*. Education pertaining to use of *DME* is covered.

    ***Pre-certification* is required for all rentals and any purchases over $1,500.**

    The following items will also be considered medical supplies:
    a. **Jobst/Compression Stockings.**
    b. **Oxygen.** Oxygen and its administration, including oxygen concentrators. Oxygen concentrators are not subject to purchase price requirements.
    c. **Sleep Apnea Oral Devices.**

    **Repair or replacement of purchased equipment if either:**
    a. the replacement is needed because of a change in your physical condition

b. it is likely to cost less to replace the item than to repair the existing item or rent a similar item

Maintenance and repairs needed due to misuse or abuse are not covered.

24. **Family History.** Charges related to services provided with a diagnosis of family history, including as covered under applicable federal law.
25. **Foot Care.** Treatment for metabolic or peripheral-vascular *disease,* plantar fasciitis, neuromas, nail bed removal, or cutting/surgical procedures when *medically necessary* and not otherwise excluded. Includes prescribed diabetic shoes limited to one (1) pair per *calendar year*. Non-custom molded foot orthotics are not covered.
26. **Gender.** Services will be considered under the applicable benefit level and limited as any other service outlined in the summary plan description. *Medically necessary* services will not be limited based on an individual's documented gender.
27. **Gene Therapy.** Health care services related to gene therapy that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. ***Pre-certification* is required.**
28. **Genetic/Genomic Testing and Counseling.** Genetic testing will only be covered after medical review has been conducted, determining the testing to be *medically necessary*. Genomic testing to examine abnormalities in groups of genes to aid in designing specific treatment options for an individual's condition, such as cancer. Amniocentesis testing is also covered. ***Pre-certification* is required.** Refer to the **Federal Notices** section for the statement of rights under the Genetic Information Nondiscrimination Act of 2008 (GINA).
29. **Habilitation Services.** Benefits include medical habilitative health care services and devices that help a *plan participant* keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings. Educational services are not covered.
30. **Hair loss.** The *Plan* will cover office visits for hair loss. Treatment for hair loss will not be covered.
31. **Hearing Devices.** Charges for services or supplies in connection with surgically implantable hearing devices, including, but not limited to, cochlear implants and exams for their fitting. Benefits include aural therapy in connection with covered implantable hearing devices which applies to the Speech Therapy benefit level.
32. **Hearing Exam.** Limited to one (1) per *calendar year* per *plan participant*.
33. **Home Health Care.** Charges for *home health care services and supplies* are covered only for care and treatment of an *illness* or *injury* when *hospital* or *skilled nursing facility* confinement would otherwise be required. The diagnosis, care, and treatment must be certified by the attending *physician* and be contained in a *home health care plan*.
    a. Benefits include payment for nursing, home health aide, nutritional guidance, therapy services, administration or infusion of prescribed drugs, and oxygen and its administration.
    b. A home health care visit will be considered a periodic visit by a *physician* acting within the scope of their license and/or as defined under *home health care services*.
    c. Private-duty nursing is only covered in the home.

    ***Pre-certification* is required.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
34. **Hospice Care.** *Hospice care services and supplies* for *plan participants* with a life expectancy of less than twelve (12) months. Services must be rendered by a state-licensed *hospice care agency* and included in a written *hospice care plan* established and periodically reviewed by the attending *physician*. The *physician* must certify the *plan participant* is terminally *ill* and that *hospital* confinement would be required in the absence of the hospice care. The *hospice care plan* shall also describe the services and supplies for palliative care and *medically necessary* treatment to be provided to the *plan participant* by the *hospice care agency*. Benefits are provided for:
    a. medical supplies
    b. visits by a *physician*
    c. skilled nursing services, home health aide services, and homemaker services given by or under the supervision or a registered nurse
    d. social services and counseling services from a licensed social worker

e. nutritional support such as intravenous feeding and feeding tubes

f. physical therapy, occupational therapy, speech therapy, and respiratory therapy

g. short-term *inpatient hospital* care when needed in periods of crisis or as respite care

h. pharmaceuticals, medical equipment, and supplies needed for the palliative care of the condition, including oxygen and related respiratory supplies

***Pre-certification* is required.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

35. **Hospital Care.** The medical services and supplies furnished by a *hospital*, *ambulatory surgical facility*, or a *birthing center*. *Covered charges* for *room and board* will be payable as shown in the applicable Schedule of Medical Benefits. ***Pre-certification* is required for inpatient admissions.**

    a. *Room and board* charges made for private rooms will be paid at the semi-private room rate (when such semi-private room rate is available), or for a *hospital* having only private rooms, based on the *hospital's* prevalent room rate.

    b. Charges for an *intensive care unit* stay are payable as described in the applicable Schedule of Medical Benefits and do not apply to the semi-private room rate.

    c. *Physician* visits to his or her patient in the *hospital* are limited to once (1) daily visit for each attending *physician* specialty during the covered period of confinement.

    d. Services for general anesthesia and related *hospital* or *ambulatory surgical center* services are covered for dental procedures if *medically necessary* and if any of the following conditions apply:

        i. The *plan participant* is under age seven (7).

        ii. The *plan participant* is disabled physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office.

        iii. The *plan participant* has a medical condition besides the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment were not done in a *hospital* or *ambulatory surgical center*.

    This benefit does not cover the *dentist's* services.

36. **Immunizations.** Immunizations and vaccinations for the purpose of travel outside of the United States.

37. **Laboratory Studies.** *Covered charges* for diagnostic lab testing and services.

38. **Mastectomy Bras and Camisoles.**

39. **Maternity and Reproductive Care.** *Pregnancy* and *complications of pregnancy* shall be covered as any other *illness* for the *employee* or spouse. *Dependent* child *pregnancy* is covered. Benefits include global pre-and post-natal care, obstetrical delivery, caesarean section, miscarriage, and complications resulting from the *pregnancy*.

    **NOTE:** Breastfeeding support, supplies, counseling, maintenance, breast milk storage supplies, pump parts, and other supplies are also available without cost sharing when services are received from a *network* or *non-network* provider, including over the counter. Benefits for breast pumps are limited to the maximums specified in the **Schedule of Benefits**.

    *Pregnancy* tests are not considered *preventive care* even when performed in conjunction with covered birth control services. Visit **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations** for a current listing of required *pregnancy*-related *preventive care* benefits.

    Delivery and hospitalization stay may be subject to *pre-certification* if over the standards set forth in the Newborns' and Mothers' Health Protection Act. Refer to the **Federal Notices** section for the statement of rights under the Newborns' and Mothers' Health Protection Act for certain protections mothers and newborns have regarding *hospital* stays.

    The Maternity and Reproductive Care Benefits also include the following:

    a. **Abortion.** Services, supplies, care, or treatment in connection with a therapeutic abortion recommended by a provider because the life of the mother is endangered by the continued *pregnancy,* or the *pregnancy* is the result of rape or incest. Elective abortions are not covered.

b. **Contraceptives**. Benefits include oral contraceptive drugs, injectable contraceptive drugs, and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the Preventive Care provisions.

c. **Infertility**. *Covered charges* include diagnostic and exploratory procedures to determine whether a *plan participant* suffers from infertility. This includes surgical procedures to correct any diagnosed *disease* or condition affecting the reproductive organs, such as, but not limited to, endometriosis, collapsed/clogged fallopian tubes, or testicular failure.

d. **Sterilization**. Male sterilization services and services to reverse a non-elective sterilization that resulted from an *illness* or *injury*. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the Preventive Care provisions.

40. **Medical Foods.** Medical foods are considered a *covered charge* if intravenous therapy (IV) or tube feedings are *medically necessary*. Medical foods taken orally are **not** covered under the *Plan*, except for PKU formula when *medically necessary*.

41. **Medical Supplies.** Charges for surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations. Also included are supplies and dressings when *medically necessary* for surgical wounds, cancer, burns, diabetic ulcers, colostomy bags and catheters, ostomy supplies, and surgical and orthopedic braces, unless covered under the **Prescription Drug Benefits** section.

42. **Mental Disorders and Substance Use Disorder.** *Inpatient* and *outpatient* treatment for *mental disorders* will be eligible when rendered by a licensed psychiatrist or licensed psychologist or when rendered by a *physician* as defined. *Inpatient* benefits include residential treatment, psychotherapy, psychological testing, electoconvulsive therapy, and detoxification. *Outpatient* benefits include office visits, therapy and treatment, *partial hospitalization*/psychiatric day treatment programs, and intensive *outpatient* programs. Family and group counseling may be covered when billed with a payable diagnosis.

    Online visits are covered for mental health disorders and substance use disorder when available in your area. *Covered charges* include a medical visit with the doctor using the internet by a webcam, chat, or voice.

    *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

    ***Pre-certification* is required for inpatient admissions, partial hospitalization, and intensive outpatient treatment.**

    Refer to the **Federal Notices** section for the statement of rights under the *Mental Health Parity and Addiction Equity Act of 2008*.

43. **Midwife Services.** Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of his/her license. This *Plan* will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries.

44. **National Health Emergency.** In the event of a declared National Health Emergency, the *Plan* will offer coverage as mandated for the condition(s) as outlined in the National Health Emergency, as required by federal regulation. The *Plan* will also cover medications authorized for emergency use by the appropriate federal agencies in the event of a public health emergency. This provision shall override any potentially conflicting, specific exclusions, defined terms, or other *Plan* provisions as necessary to provide, and limited to, any mandated services as outlined in the public health emergency, and corresponding regulation(s). Such coverage shall remain in effect until the public health emergency, as declared by the governing federal agency, has ended.

45. **Neuropsychological Testing.** Tests used to evaluate patients who have experienced a traumatic brain injury, brain damage, or organic neurological problems (e.g., dementia). May also be used to evaluate the progress of a patient who has undergone treatment or rehabilitation for a neurological *injury* or *illness*.

46. **Obesity Services.** Prescription drugs and any other services or supplies for the treatment of obesity are covered. Counseling and bariatric surgical treatment of obesity is only covered for patients meeting *medical necessity* criteria, as defined by the *Plan*. ***Pre-certification* is required**.

47. **Occipital Nerve Blocks/Injections.**

48. **Online Visits.** When available in your area, your coverage will include online visit services with LiveHealth Online. *Covered charges* include a medical consultation using the internet via a webcam, chat, or voice. *Covered charges* will be payable as shown in the Schedule of Medical Benefits. *Covered charges* do not include reporting normal lab or other test results; requesting office visits; getting answers to billing, insurance coverage, or payment questions; asking for referrals to doctors outside the online care panel; benefit *pre-certification*, or doctor-to-doctor discussions.

49. **Oral Surgery.** Care of the mouth, teeth, gums, and alveolar processes will be *covered charges* under this *Plan* only if that care is for the following conditions and oral *surgical procedures*:

    a. fracture of facial bones

    b. removal of bony impacted teeth

    c. lesions of the mouth, lip, or tongue which require a pathological exam

    d. incision of accessory sinuses, mouth salivary glands, or ducts

    e. dislocations of the jaw

    f. treatment of temporomandibular joint syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services

       *Covered charges* do not include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures)

    g. plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments

    h. initial services, supplies, or appliances for dental care or treatment required as a result of, and directly related to, *accidental injury* to sound natural teeth or structure occurring while a *plan participant* is covered by this *Plan* and performed within the time frames shown in the Schedule of Medical Benefits

    i. orthognathic surgery/LeFort procedures for a physical abnormality that prevents normal function of the upper and/or lower jaw and is *medically necessary* to attain functional capacity of the affected part

    j. oral/surgical correction of *accidental injuries*

    k. treatment of non-dental lesions, such as removal of tumors and biopsies

    l. incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses

    ***Pre-certification* is required.** Dental anesthesia is covered only if related to a covered oral surgery.

    No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease,* and preparing the mouth for fitting of or continued use of dentures.

50. **Orthotic Appliances.** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints, cranial helmets, or other appliances which are required for support for an *injured* or deformed part of the body as a result of a disabling congenital condition or an *injury* or *illness*. Benefits for repair or replacement of an orthotic appliance due to normal use, adolescent growth, or pathological changes will be provided. Coverage for orthotic appliances includes the following:

    a. **Foot Orthotics**. Based on medical necessity.

    b. **Cataract Surgery.** Services and supplies associated with cataract *surgery*, including the initial purchase of eyeglasses or contact lenses following each *surgery*.

    c. **Wigs.** Charges associated with the initial purchase of a wig, toupee, or hairpiece after chemotherapy or radiation therapy, limited to one (1) wig per *calendar year*.

51. **Pain Management.** When *medically necessary*.

52. **Pervasive Developmental Disorder (Autism).** Includes services for testing, office visits, habilitation therapy, and consultations.

53. **Physician Care.** The professional services of a *physician* for medical services. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed the *maximum allowable charge*.

    Charges for multiple *surgical procedures* will be a *covered charge* subject to the following provisions:

    a. If bilateral or multiple *surgical procedures* are performed by one (1) surgeon, benefits will be determined based on the *maximum allowable charge* that is allowed for the primary procedures; the *maximum allowable charge* will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental, and no benefits will be provided for such procedures.

    b. If multiple unrelated *surgical procedures* are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the *maximum allowable charge* for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1)

surgeon, benefits for all surgeons will not exceed the *maximum allowable charge* allowed for that procedure.

c. If a co-surgeon is required, meaning skills of both surgeons are necessary to perform distinct parts of a specific operative procedure, payment is based for each physician on the *maximum allowable charge*, dividing the payment equally between the two (2) surgeons. *Surgeries* performed by co-surgeons that have the same specialty are not covered under the *Plan,* unless *medically necessary*

54. **Pre-Admission Testing.** Includes diagnostic labs, x-rays, and EKGs that you obtain on an *outpatient* basis prior to your scheduled admission to the *hospital*. However, you should make sure your *hospital* will accept the results of these tests and not simply repeat them.

55. **Prenatal Testing.** Services for prenatal diagnosis or congenital disorders of the fetus by means of screening and diagnostic procedures will be provided the same as for any other condition during your covered *pregnancy*. Such services must be *medically necessary*.

56. **Preventive Care.** Benefits will be provided for *preventive care*, including, but not limited to:

    a. **Immunizations.** Pediatric and adult preventive vaccinations, inoculations, and immunizations according to the age and frequency limitations established by the Centers for Disease Control and Prevention (CDC), including, but not limited to:

        i. **HPV Vaccine.** For male and female *plan participants* ages nine (9) to twenty-six (26).

        ii. **Influenza Vaccine.**

        iii. **Shingles Vaccine.**

    The *Plan* contributes to at least one (1) state-funded vaccination program, which covers the provider's costs associated with immunization serum for eligible, minor children up to the age of nineteen (19). Should a provider bill a vaccine charge for a child who is covered by that state's immunization program, regardless of their eligibility under the *Plan*, the *Plan* will consider its financial obligation of that *claim* satisfied through its contribution to the state funded immunization program and will not remit payment for that *claim*, except as may be required by applicable federal law. The administration of immunizations is covered.

    b. **Adult Physical Examination, Well-Baby, and Well-Child Examinations.**

    c. **Gynecological Exam, Prostate Specific Antigen Test, and Mammogram.**

    d. **Colorectal Cancer Screening.**

    e. **Contraceptives.** Injections, implants, devices, and associated *physician* charges are covered under the Medical Benefits of this *Plan*. Self-administered contraceptives are covered under the Prescription Drug Benefits.

    f. **Pap Smear.** Limited to one (1) per year for female *plan participants* ages twenty-one (21) through sixty-five (65).

    g. **Smoking Cessation.** Counseling for tobacco cessation up to eight (8) visits per *calendar year*. Prescription drugs and other products for tobacco cessation are covered under the **Prescription Drug Benefits**.

    h. **Sterilization.** Services for tubal ligation or other voluntary sterilization procedures for female *plan participants*.

    **NOTE:** Additional *preventive care* shall be covered as required by applicable law if provided by a *network* provider. A current listing of required *preventive care* can be accessed at:

    **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**.

    If you choose to go to a *non-network* provider for preventive care, you are responsible for any balance between the *non-network* provider's charge and the *maximum allowable charge*.

57. **Prosthetic Devices.** The initial purchase of artificial limbs, eyes, and breast prostheses, including service and repair of an artificial limb, eye, or breast prosthesis, but not replacement of such items the attending *physician* indicates *medical necessity* due to a change in the body condition, and the artificial limb or eye cannot be repaired or made serviceable.

Covered charges do not include expenses for corrective shoes; dentures; replacing teeth or structures directly supporting teeth, except to correct traumatic *injuries*; electrical or magnetic continence aids; or implants for cosmetic purposes, except for reconstruction following a mastectomy.

58. **Reconstructive Surgery.** Reconstructive *surgery* expenses are covered in the following circumstances:
    a. when needed to correct damage caused by congenital or developmental abnormalities resulting in the malformation or absence of a body part
    b. to correct damage caused by an *accidental injury*
    c. for breast reconstruction following a total or partial *mastectomy*, as follows:
        i. reconstruction of the breast on which the *mastectomy* has been performed
        ii. *surgery* and reconstruction of the other breast to produce a symmetrical appearance
        iii. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

    All other reconstructive *surgeries* will be covered under the *Plan* when *medically necessary*.

    ***Pre-certification* is required.** Refer to the **Federal Notices** section for the statement of rights to *surgery* and prostheses following a covered *mastectomy* under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

59. **Routine Newborn Care.** Routine well-baby care is care while the newborn is *hospital*-confined after birth and includes *room and board* and other normal care for which a *hospital* makes a charge
    a. This coverage is only provided if the newborn child is an eligible *dependent* and a parent either:
        i. is a *plan participant* who was covered under the *Plan* at the time of the birth
        ii. enrolls himself/herself (as well as the newborn child if required) in accordance with the *Plan* provisions with coverage effective as of the date of birth
    b. The benefit is limited to *allowable charges* for well-baby care after birth while the newborn child is *hospital* confined as a result of the child's birth.
    c. Should the newborn require other than routine nursery care, the baby will be admitted to the *hospital* in his or her own name.

60. **Second Surgical Opinion.** If your doctor recommends *surgery* or other medical treatment, it is often in your best interest to obtain a second opinion with a specialist regarding the necessity of the procedure. In many cases an alternative method of treatment is available that would save yourself the discomfort of *surgery* or other medical treatment as well as the time and extra expenses.

61. **Skilled Nursing Facility.** The *room and board* and nursing care furnished by a *skilled nursing facility* will be payable if and when:
    a. The patient is confined as a bed patient in the facility and requires continuous *physician* and nursing care.
    b. The attending *physician* certifies that the confinement is needed for further care of the condition that caused the *hospital* confinement.
    c. The attending *physician* completes a treatment plan which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the *skilled nursing facility*.

    If a *plan participant* stays in a private room, this *Plan* pays the semi-private room rate toward the charge for the private room, or for a *hospital* having only private rooms, based on the *hospital's* prevalent room rate.

    Benefits will not be provided when a *plan participant* reaches the maximum level of recovery possible and no longer requires other than routine care.

    ***Pre-certification* is required for inpatient admissions.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

62. **Sleep Disorders/Sleep Studies.** Care and treatment for sleep disorders, including sleep studies performed in the home.

63. **Sterilization.** Services for vasectomy or other voluntary sterilization procedures for male *plan participants*. Female sterilization and family planning counseling is covered under the Preventive Care provision of this *Plan*. The *Plan* does not cover the reversal of voluntary sterilization procedures, including related follow-up care.

64. **Surgery.** Benefits for the treatment of *illnesses* and *injuries,* including fractures, dislocations, and injections and their administration, are covered for the surgeon, assistant surgeon, anesthesiologist, and surgical supplies. ***Pre-certification*** **is required for outpatient surgical procedures** (excluding outpatient office surgical procedures).

65. **Therapy Services.** Services include physical therapy, occupational therapy, and speech therapy rendered on an *inpatient* or *outpatient* basis. *Outpatient* rehabilitation therapies accumulate toward the maximum shown in the applicable **Schedule of Benefits**. Therapy in the home applies to the home health care maximum.

    a. **Cognitive Therapy.**

    b. **Occupational Therapy**.

    c. **Orthoptic/Vision Training.**

    d. **Physical Therapy**. The therapy must be for conditions which are subject to significant improvement through short-term therapy. Services include aquatic therapy. Wound debridement services do not apply toward the Rehabilitation Therapy maximum and do not require *pre-certification*.

    e. **Speech Therapy**. Therapy must be supervised and ordered by a *physician*.

    **Rehabilitation Services.** The *Plan* covers rehabilitation services to help a *plan participant* achieve a previous level of function, independence, and quality of life.

    **Habilitation Services.** The *Plan* covers *habilitation services* that help a *plan participant* keep, learn, or improve skills and functions for daily living that they may not be developing as expected for their age range.

66. **Transplants.** Services and supplies that are *incurred* for care and treatment due to an organ or tissue transplant are subject to the limits stated in the **Transplant Program** section. ***Pre-certification*** **is required.**

67. **Travel Expenses.** Covered travel and lodging expenses for *plan participants* receiving services at a designated *network* facility. The *Plan* covers expenses for travel and lodging for the *plan participant* up to a total maximum of $10,000 per incident.

    Reimbursement for travel expenses are only covered when you are required to travel more than seventy-five (75) miles from your residence to reach the facility where your covered procedure will be performed. You must obtain prior approval. The *Plan's* assistance with travel expenses includes transportation to and from the facility and lodging for the *plan participant* and one (1) companion for an adult patient, or two (2) companions for a child patient. A $50 per day lodging maximum will be applied for the patient or up to $100 per day for the patient and one (1) companion.

    These benefits will be reimbursed upon the submission to the *Plan* of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service provider. Refer to the **Claims and Appeals** section for instructions on how to submit a claim for reimbursement. The listed expenses must be *incurred* within five (5) days prior to the procedure and one hundred twenty (120) days after the procedure. The *Plan Administrator* reserves the right not to reimburse any such expenses that it, in its sole discretion, deems inappropriate, excessive, or not in keeping with the intent of this provision.

68. **Virtual Visits.** Services rendered telephonically or electronically, performed by providers other than the *Plan's* telemedicine vendor, when performed for otherwise covered services.

69. **X-Rays.** Diagnostic X-rays.

**B. Medical Plan Exclusions**

The following list is intended to give you a general description of expenses for services and supplies that are not covered by the *Plan*. Items that are not listed as excluded may be considered based on *medical necessity*, standard of care, and medical appropriateness. This list is not exhaustive.

**NOTE: All exclusions related to prescription drugs are shown in the Prescription Drug Benefits section.**

1. **Abortion.** Services, supplies, care, drugs, or treatment in connection with an abortion unless the life of the mother is endangered by the continued *pregnancy* or the *pregnancy* is the result of rape or incest.
2. **Allergy Services.** Specific non-standard allergy services and supplies, including, but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
3. **Alternative Medicine.** Holistic or homeopathic treatment, naturopathic services, acupressure, hypnotherapy, hypnosis, aroma therapy, massage therapy at a salon, biofeedback, reiki therapy, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique, iridology, sleep therapy, and thermography, including drugs. This exclusion also applies to self-care or non-medical self-help training and any related diagnostic testing.
4. **Armed Forces.** Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any *plan participant* in the armed forces of a government.
5. **Athletic Training.**
6. **Before or After Eligibility.** Services, supplies, or accommodations provided prior to the *plan participant's* effective date or after the termination of coverage. In the event coverage is terminated during a *hospital* admission, the *Plan* will only consider *covered charges* as those *incurred* before coverage was terminated.
7. **Behavioral.** Educational services for behavioral problems and learning disabilities; behavior modification, intensive behavior interventions, sensitivity training, hypnosis, or electro-hypnosis; special education for learning deficiencies or behavioral problems, whether or not associated with a manifest *mental disorder* or other disturbances.
8. **Biomicroscopy.** Biomicroscopy, field charting, or aniseikonic investigation.
9. **Chelation Therapy.** Except for lead poisoning.
10. **Clinical Trials.** The following items are excluded from *approved clinical trial* coverage under this *Plan*:
    a. the *investigational* item, device, or service, itself
    b. items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the patient
    c. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

    If one (1) or more *participating providers* do participate in the *approved clinical trial*, the qualified *plan participant* must participate in the *approved clinical trial* through a participating, *network* provider, if the provider will accept the *plan participant* into the trial.

    The *Plan* does not cover routine patient care services that are provided outside of this *Plan's* health care provider *network* unless *non-network* benefits are otherwise provided under this *Plan*.
11. **Complications from a Non-Covered Service.** Care, services, or treatment required as a result of complications from a treatment not covered under the *Plan*. Complications directly related to cosmetic services and which would not have taken place in the absence of the cosmetic services. Complications from a non-covered abortion are covered. This exclusion does not apply to conditions including myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.
12. **Cord Blood.** Harvesting and storage of umbilical cord blood.
13. **Cosmetic.** Cosmetic or reconstructive procedures and attendant hospitalization, except for newborn children or due to trauma or *disease*, done for aesthetic purposes and not to restore an impaired function of the body. Cosmetic procedures will not be covered regardless of the fact that the lack of correction causes emotional or psychological effects. Complications or subsequent *surgery* related in any way to any previous cosmetic procedure shall not be covered, regardless of *medical necessity*. This exclusion includes, but it not limited to, surgery to correct gynecomastia, breast augmentation procedures, and otoplasties. Reduction mammoplasty and

services for the correction of asymmetry, except when determined to be *medically necessary* by MyQHealth Care Coordinators, is not covered.

This exclusion does not apply to covered reconstructive services under this *Plan* breast reconstruction surgery.

14. **Counseling.** Benefits for counseling in the absence of *illness* or *injury*, including, but not limited to, premarital or marital counseling; religious counseling; education, social, behavioral, or recreational therapy; sex or interpersonal relationship counseling; or counseling provided by a *plan participant's* friends, *employer*, school counselor, or school teacher. Family and group counseling may be covered when billed with a payable diagnosis.
15. **Court-Ordered Treatment.** Any treatment of a *plan participant* in a public or private *institution* as the result of a court order or commitment unless *medically necessary* and approved by the *Plan*. This exclusion does not apply to *mental health or substance use disorder holds*, as they are not court-ordered treatments.
16. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, or *custodial care*.
17. **Daily Room Charges.** Daily room charges while the *Plan* is paying for an intensive care, cardiac care, or other special care unit.
18. **Dental Care.** Normal dental care benefits, including any dental, gum treatments, or oral *surgery* except as otherwise specifically provided herein.
19. **Developmental Delay.** Educational and non-medical services for *developmental delay* are not covered.
20. **Diabetic Supplies.** Diabetic supplies are covered through the Prescription Drug Benefits program. Please refer to the section entitled **Prescription Drug Benefits**.
21. **Dialysis.** Refer to **Outpatient Dialysis Services** section for coverage.
22. **Educational or Vocational Testing.** Services for educational or vocational testing or training, except as listed herein.
23. **Error.** Any charge for care, supplies, treatment, and/or services that are required to treat *injuries* that are sustained, or an *illness* that is contracted, including infections and complications, while the *plan participant* was under, and due to, the care of a provider wherein such *illness*, *injury*, infection, or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the *Plan Administrator*, in its sole discretion, unreasonably gave rise to the expense.
24. **Examinations.** Any health examination required by any law of a government to secure insurance or school admissions (including sports physicals), professional or other licenses, except as required under applicable federal law.
25. **Excess Charges.** Any charge for care, supplies, treatment, and/or services that are not payable under the *Plan* due to application of any *Plan* maximum or charges which are in excess of the *maximum allowable charge*, or services not deemed to be *reasonable* or *medically necessary*, based upon the *Plan Administrator's* determination as set forth by and within the terms of this document.
26. **Exercise Programs.** Exercise programs for treatment of any condition, except for *physician* supervised cardiac rehabilitation, occupational, or physical therapy, if covered by this *Plan*.
27. **Experimental/Investigational.** Care and treatment that is *experimental/investigational*. This exclusion shall not apply if the charge is for routine patient care for costs *incurred* by a *qualified individual* who is a *participant* in an *approved clinical* trial, or if a charge is *incurred* by a *plan participant* for occipital nerve injections. Charges will be covered only to the extent specifically set forth in this summary plan description.
28. **Foot Care.** Services for routine, palliative, or cosmetic foot care including flat foot conditions, supportive devices for the foot (orthotics), treatment of subluxation of the foot, care of corns, bunions (except capsular or bone *surgery*), callouses, toe nails, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, unless specifically provided herein.
29. **Foreign Travel.** Expenses for planned and/or routine services received or supplies purchased outside the United States, including those rendered on a cruise ship are excluded under this *Plan*. Services in the case of a *medical emergency* are a *covered charge*.
30. **Government Coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government, except as stated herein. This exclusion does not apply to Medicaid, a Veteran's Administration facility, or when otherwise prohibited by applicable law. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military service-related *illness* or *injury*, benefits are not covered by this *Plan*. If a *plan participant* receives services in a U.S.

Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military service-related *illness* or *injury*, benefits are covered by the *Plan* to the extent those services are *medically necessary* and the charges are within this *Plan's maximum allowable charge*.

31. **Growth Hormones.**
32. **Hair Loss.** Treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a *physician*, except for wigs in conjunction with chemotherapy and/or radiation therapy.
33. **Health Spa.** Expenses incurred at a health spa or similar facility.
34. **Hearing Aids.** Charges for services or supplies in connection with hearing aids, exams for their fitting, or batteries. Surgically implantable hearing devices may be covered as specified.
35. **Home Health Care.** Covered services for home health care do not include food, housing, homemaker services, sitters, home-delivered meals, custodial care, dietician services, maintenance therapy, dialysis treatment, purchase or rental of dialysis equipment, or any services for any period during which the *plan participant* is not under the continuing care of a *physician*.
36. **Home Visits.** When a provider visits the home for covered services, commonly known as a 'house call.' This is separate from home health care and therapy done in the home.
37. **Hospice Care.** Services for pastoral or spiritual counseling; services performed by a family member or volunteer workers, homemaker, or housekeeping services; food services (such as Meals on Wheels); legal and financial counseling services; and services or supplies not included in the *hospice care plan* or not specifically set forth as a hospice benefit.
38. **Hospital Employees.** Professional services billed by a *physician* or nurse who is an *employee* of a *hospital* or *skilled nursing facility* and paid by the *hospital* or facility for the service.
39. **Hospital Services.** *Hospital* services when hospitalization is primarily for *diagnostic testing*/studies or physical therapy when such procedures could have been done adequately and safely on an *outpatient* basis.
40. **Illegal Acts.** Any charge for care, supplies, treatment, and/or services for any *injury* or *illness* which is *incurred* by a *plan participant* who is convicted of taking part or attempting to take part in a felony. Care required while incarcerated in a federal, state, or local penal institution or required while in the care of federal, state, or law enforcement authorities is also excluded, unless otherwise required by law. This exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
41. **Immediate Family Member.** Any charge for care, supplies, treatment, and/or services that are rendered by a close relative, member of the immediate *family unit*, or person residing in the same household, including spouse, parent, grandparent, child, brother, or sister, by blood, marriage (including in-laws), or adoption.
42. **Impotence.** Care, treatment, services, supplies, or medication in connection with treatment for impotence, regardless of origin or cause, except male organic erectile dysfunction. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction. Diagnostic testing may be covered.
43. **Ineligible Provider.** Any services rendered or supplies provided while you are confined to an ineligible *hospital* or while you are a patient of an ineligible provider.
44. **Infertility.** Care, supplies, services, and treatment for *infertility*, including artificial insemination, in vitro fertilization, or any assisted reproductive technology (ART) procedure, except for *diagnostic services* rendered for *infertility* evaluation and treatment of an underlying medical condition.
45. **Inpatient Rehabilitation.** *Inpatient* rehabilitation in a *hospital* or hospital-based rehabilitation facility under any of the following conditions:
    a. The *plan participant* is medically stable and does not require skilled nursing care or the constant availability of a *physician*.
    b. The treatment is for maintenance therapy.
    c. The *plan participant* has no restorative potential.
    d. The treatment is for congenital learning or neurological disability/disorder.
    e. The treatment is for communication training, educational training, or vocational training.
46. **Long Term Care.**

46. **Maternity.** Charges for services related to a scheduled home birth. Charges for services related to surrogate *pregnancy*.

47. **Medicare.** Any charge for benefits that are provided, or which would have been provided had the *plan participant* enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (*Medicare*), including any amendments thereto, or under any federal law or regulation, except as provided in the sections entitled **Coordination of Benefits** and **Medicare**.

48. **Milieu Therapy.** A treatment program based on manipulation of the *plan participant's* environment for their benefit.

49. **Negligence.** Care and treatment of an *injury* or *illness* that results from activity where the *plan participant* is found by a court of competent jurisdiction and/or a jury of his/her peers to have been negligent in his/her actions, as negligence is defined by the jurisdiction where the activity occurred.

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

51. **No Legal Obligation.** Any charge for care, supplies, treatment, and/or services that are provided to a *plan participant* for which the provider of a service customarily makes no direct charge, for which the *plan participant* is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including, but not limited to, fees, care, supplies, or services for which a person, company, or any other entity except the *plan participant* or this benefit *Plan*, may be liable for necessitating the fees, care, supplies, or services.

52. **No Physician Recommendation.** Care, treatment, services, or supplies not recommended and approved by a *physician*. Treatment, services, or supplies when the *plan participant* is not under the regular care of a *physician*. Regular care means ongoing medical supervision or treatment which is appropriate care for the *injury* or *illness*.

53. **No Signs or Symptoms.** Charges for screenings, treatment, or services in the absence of signs or symptoms of a specific *injury*, *illness*, or *pregnancy*-related condition which is known or reasonably suspected, unless such care is specifically covered herein or required by applicable federal law.

54. **Non-Emergency Hospital Admissions.** Care and treatment billed by a *hospital* for *medical non-emergency care* admissions on a Friday or a Saturday. This does not apply if *surgery* is performed within twenty-four (24) hours of admission. Admission or continued *hospital* or *skilled nursing facility* stay for medical care or diagnostic studies not medically required on an *inpatient* basis.

55. **Non-Medical Expenses.** Expenses including, but not limited to, those for preparing medical reports or itemized bills; completion of claim forms or medical records unless otherwise required by law; calling a patient to provide their test results; sales tax; shipping and handling; reports prepared in connection with litigation; educational brochures; *physician* or *hospital* stand-by services; holiday or overtime rates; expenses for failure to keep a scheduled visit or appointment; or membership, administrative, or access fees charged by providers.

56. **Non-Prescription Medication.** Drugs and supplies not requiring a prescription order (unless required under applicable federal law), including, but not limited to, aspirin, antacid, benzyl peroxide preparations, cosmetics, medicated soaps, food supplements, syringes, bandages, Methadone, or Rogaine hair preparations, special foods or diets, vitamins, minerals, dietary and nutritional supplements, *experimental* drugs, including those labeled "Caution: Federal law prohibits dispensing without prescription," and prescription medications related to health care services which are not covered under this *Plan*.

57. **Not Actually Rendered.** Any charge for care, supplies, treatment, and/or services that are not actually rendered.

58. **Not Medically Necessary.** Any charge for care, supplies, treatment, and/or services that are not *medically necessary*, unless specifically stated as covered herein.

59. **Obesity/Morbid Obesity.** Screening and counseling for obesity will be covered to the extent required under applicable federal law. Other care or treatment of obesity, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another *illness*, is not covered under the *Plan*, unless specifically stated herein. Weight loss programs and reversals for weight loss *surgery* are excluded.

60. **Occupational or Workers' Compensation.** Care for any condition or *injury* recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease, or similar law. If Workers' Compensation Act benefits are not available to you, then this exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

61. **Other than Attending Physician.** Any charge for care, supplies, treatment, and/or services by a *provider* who did not render an actual service to the *participant*. *Covered charges* are limited to those certified by a *physician* who is attending the *plan participant* as required for the treatment of *injury* or *disease*, and performed by an appropriate provider. Staff consultations required by hospitals are excluded. This exclusion does not apply to interdisciplinary team conferences to coordinate patient care. Referrals are not considered consultations under this *Plan*.
62. **Personal Comfort Items.** Personal convenience or comfort items or other equipment or services not directly related to medical care, such as, but not limited to, guest meals and accommodations, barber services, homemaker services, travel expenses, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, retail blood pressure instruments, scales, elastic bandages, non-medical grade stockings, non-*prescription drugs* and medicines, first-aid supplies, seat risers, non-hospital adjustable beds, emergency alert equipment, and furnishings to provide a safe surrounding from exposure that can worsen a *disease* or *injury*.
63. **Personal Injury Insurance.** Expenses in connection with an automobile *accident* for which benefits payable hereunder are, or would be otherwise covered by, mandatory *no-fault automobile insurance* or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the *plan participant* actually had such mandatory coverage. This exclusion does not apply if the *injured* person is a passenger in a non-family-owned vehicle or a pedestrian.
64. **Prescription Drugs.** Prescription drugs charges covered under the **Prescription Drug Benefits**, other than those covered in a *physician's* office or *inpatient* admission.
65. **Private Duty Nursing.** Charges in connection with care, treatment, or services of a private duty nurse except when provided through home health care.
66. **Prohibited by Law.** Any charge for care, supplies, treatment, and/or services to the extent that payment under this *Plan* is prohibited by law.
67. **Prosthetic Devices.** Corrective shoes; dentures; replacing teeth or structures directly supporting teeth, except to correct traumatic *injuries*; electrical or magnetic continence aids; or implants for cosmetic purposes, except for reconstruction following a mastectomy.
68. **Repair of Purchased Equipment.** Maintenance and repairs needed due to misuse or abuse are not covered.
69. **Replacement Devices.** Replacement of orthotics or prosthetics such as braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the *plan participant's* physical condition to make the original device no longer functional.
70. **Research Screenings.** Examinations related to research screenings, unless required by law.
71. **Residential Accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a *hospital*, hospice, *skilled nursing facility*, or residential treatment center. Improvements to a *plan participant's* house, place of business, or vehicles.
72. **School Setting.** Services performed in a school setting. This exclusion also applies to services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school.
73. **Smoking Cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under the Preventive Care provision. Refer to the **Prescription Drug Benefits** section for details on coverage of certain tobacco cessation medications.
74. **Spider Veins.** Treatment of telangiectatic dermal veins (spider veins) by any method.
75. **Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.
76. **Subrogation, Reimbursement, and/or Third Party Responsibility.** Any charges for care, supplies, treatment, and/or services of an *injury* or *illness* not payable by virtue of the *Plan's* subrogation, reimbursement, and/or third party responsibility provisions. Refer to the **Reimbursement and Recovery Provisions** section.
77. **Therapy Services.** Services for *outpatient* therapy or rehabilitation other than those specifically listed as covered in this summary plan description. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, electromagnetic therapy, salabrasion, chemosurgery, and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes, and/or which are performed as a treatment for acne.

78. **Transplants.** Services and supplies that are *incurred* for care and treatment due to a bone marrow, organ, or tissue transplant are subject to the exclusions stated in the **Transplant Program** section.

79. **Travel Expenses.** Charges for travel accommodations or mileage costs, whether or not recommended by a *physician*, except for ambulance charges defined as a *covered charge* or travel required for an approved organ or tissue transplant or adoptive cell therapy. Ambulance services are not covered when another type of transportation can be used without endangering your health. Coverage for ambulance services does not include trips to a doctor's office or clinic, morgue, funeral home, or for the convenience of a *plan participant* or provider. Any of the following or similar items associated with travel:

    a. entertainment items such as alcohol, cigarettes, toys, books, movies, theater tickets, theme park tickets, flowers, greeting cards, stationary, stamps, postage, gifts, internet service, tips, coupons, vouchers, or travel tickets, frequent flyer miles

    b. convenience items such as toiletries, paper products, maid service, laundry/dry cleaning, kennel fees, baby sitter/childcare, faxing, cell phones, phone calls, newspapers

    c. mortgage, rent, security deposit, furniture, utility bills, appliances, utensils, vacation/apartment rentals

    d. vehicle maintenance, automobile mileage, taxi fares, parking, moving trucks/vehicles, mileage within the medical transplant facility city

    e. cash advances/lost wages

    f. rental cars, buses, taxis, or shuttle service, except as specifically approved by the *Claims Administrator*

    g. prepayments or deposits

    h. taxes

80. **Vision Care Exclusions.** Expenses for the following:

    a. surgical correction of refractive errors and refractive keratoplasty procedures, including, but not limited to, Radial Keratotomy (RK), Automated Lamellar Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK)

    b. diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting, and repair of eyeglasses or lenses and associated supplies, except one (1) pair of eyeglasses or contact lenses is payable as following ocular *surgery* when the lens of the eye has been removed such as with a cataract extraction or soft contact lenses due to a medical condition such as diabetes

        This exclusion applies even when services are performed in conjunction with a medical diagnosis, except as stated above.

    c. orthokeratology lenses for reshaping the cornea of the eye to improve vision

    d. specialty lenses such as polarized lenses, transition lenses, coatings, tints, or add-ons

81. **War.** Any loss that is due to a declared or undeclared act of war, any military duty, or any release of nuclear energy.

# SECTION VII—OUTPATIENT DIALYSIS SERVICES

The following *outpatient dialysis* services are not included under the *network* arrangement of this *Plan:*

1. facility and professional charges from:
    a. *outpatient hospitals*
    b. dialysis facilities
2. home dialysis charges

### A. Coordination with Medicare

If you are diagnosed with a condition requiring dialysis, you may be able to enroll in *Medicare*. Upon beginning dialysis treatments, *Medicare*, if applicable, will coordinate benefits with the *Plan* as the secondary payer for months four (4) through thirty-three (33) of the coordination period while you are receiving dialysis treatments. Your *outpatient* dialysis medical *claims* as described in this section will be considered at 125% of *Medicare's* reimbursement level.

The *Plan* will not enroll you in *Medicare*; it is your decision and your responsibility to enroll in *Medicare*, if applicable.

If you are eligible but do not enroll for both Part A and Part B of *Medicare*, the *Plan* will pay benefits as if you have enrolled. Your *claims* will be reduced as secondary under this *Plan* regardless of enrollment status under *Medicare*.

Refer to the **Coordination of Benefits** and **Medicare** sections of this document for more information.

### B. Medical Management

**All dialysis services require *pre-certification*.** To begin the *pre-certification* process, call AmeriBen at 1.866.215.0975.

### C. ID Cards

*Plan participants* requiring dialysis services will be issued a separate Dialysis Identification Card. This card will be sent to you by AmeriBen upon your initial *pre-certification* call.

### D. Submitting Outpatient Dialysis Claims

All *outpatient* dialysis medical *claims* will be submitted to:

AmeriBen
P.O. Box 7186
Boise, ID 83707

Please refer to the **Claims and Appeals** section for information regarding filing *claims*.

# SECTION VIII—TRANSPLANT PROGRAM

## A. Transplant Program

The Transplant Program provides access to a *network* of transplant centers that perform many transplants each year and have historically high success rates. They are often affiliated with renowned teaching and research facilities with access to experienced surgeons and advanced medical techniques. Using a *hospital* with transplant experience can result in shorter *hospital* stays, fewer complications, and fewer repeat transplants.

Under the Transplant Program, the *Plan* reimburses you for covered services and supplies arising out of, any medically necessary human organ and stem cell/bone marrow transplant and transfusion for a *plan participant* recipient as determined by MyQHealth Care Coordinators, including the following the following:

1. bone marrow
2. cornea
3. double lung
4. heart
5. heart/lung
6. intestine
7. kidney
8. kidney/liver
9. kidney/pancreas
10. liver
11. pancreas

When the donor of an organ or tissue is not a *plan participant*, the donor's *hospital*, surgical, and medical expenses will be eligible on the basis of a *claim* made by the *plan participant*. Benefits are offered only when not available to donor from any other source. *Medically necessary* charges for procurement of an organ from a live donor are covered up to the *maximum allowed amount*, including complications from the donor procedure for up to six (6) weeks from procurement date.

Medical and surgical treatment or devices related to transplantation that are *experimental*, *investigational*, or unproven are those not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, subject to review and approval by any institutional Review Board for the proposed use; or non-demonstrative through prevailing peer-reviewed medical literature to be efficacious for the treatment of the *disease* state at the time of the request. The *Plan* reserves the right to make final judgment regarding coverage of *experimental*, *investigational*, and unproven procedures and treatments. *Medically necessary* means those transplant-related services which are determined by the *Plan* to be medically appropriate for the diagnosis and clinical status of the *plan participants* and their *dependents*, rendered in an appropriate setting, and of demonstrated medical value. The fact that a *physician* has performed or prescribed a transplant-related service, or the fact that it may be the only treatment for a *disease* does not mean that is *medically necessary*.

Transplant-related services are services and supplies related to transplantation when recommended by a *physician*, provided at or arranged by a transplant *hospital*, and determined to be *medically necessary*. Such services and supplies include but are not limited to: *hospital* charges; *physician* charges; organ acquisition charges; tissue typing donor search charges; and collection, storage, and ancillary services, including medically necessary preparatory myeloablative therapy.

## B. Program Benefits

1. access to a Blue Distinction Center of Excellence (BDCT) or *network* transplant provider
2. services of a transplant case manager, who will coordinate services and savings

Please note that there are instances where your provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for *medical necessity* and

may be approved. However, such an approval for HLA testing, donor search, and/or collection and storage is NOT an approval for the subsequent requested transplant. A separate *medical necessity* determination will be made for the transplant procedure.

### C. Covered Transplant Benefit Period

The covered transplant benefit period starts one (1) day prior to a covered transplant procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the *network* transplant provider agreement. Contact MyQHealth Care Coordinators for specific *network* transplant provider information for services received at or coordinated by a *network* transplant provider facility or starts one (1) day prior to a covered transplant procedure and continues to the date of discharge at a *non-network* transplant provider facility.

### D. Requirements

Transplant benefits under the *Plan* are only available when a *plan participant* fully utilizes a Blue Distinction Center or *network* transplant provider and meets all of the following requirements:

Pre-certification of the upcoming transplant **must** be given by the *plan participant* or the *plan participant's physician* as soon as the *plan participant* is identified as a potential transplant candidate. You must do this before you have an evaluation and/or work-up for a transplant. *Pre-certification* **must** be obtained as outlined in the **Care Coordination Program** section.

1. All transplant services must be rendered at a transplant center facility.

   Certain transplant procedures are not available at a Blue Distinction Center. In these instances, *plan participants* may have access to the closest available *network* transplant provider that performs the procedure. Note that even if a hospital is a network provider for other services, it may not be a *network* transplant provider for these services. Please contact MyQHealth Care Coordinators to determine which hospitals are *network* transplant providers.

   The Blue Distinction Center requirements do not apply to cornea and kidney transplants and any covered charges related to a covered transplant procedure received prior to or after the transplant benefit period.

**If these requirements are not met, transplant benefits are not available under the Plan.**

### E. Transplant Exclusions

The following transplant-related expenses are not covered by the *Plan*:

1. when the recipient is not an eligible *plan participant*
2. when the organ or tissue is sold rather than donated to the recipient
3. charges related to transportation costs, including without limitation ambulance or air services for the donor or to move a donated organ or tissue
4. charges that are covered or funded by governmental, foundation, or charitable grants or programs
5. charges for any artificial or mechanical organ

   This exclusion does not apply to cardiac assist devices such as LVAD's.

# SECTION IX—CARE COORDINATION PROGRAM

## A. Introduction

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

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

**Care Coordinators: 1.888.971.7377**

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

## B. Care Coordination Requirements

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

The Care Coordination process generally includes:

1. use of *network* providers
2. designating a Coordinating Provider (PCP)
3. the Care Coordination Process and utilization management
    a. pre-certification and clinical review
    b. concurrent utilization review
    c. personal care guide management

### Use of Network Providers

The *Plan* offers a broad *network* of providers and provides the highest level of benefits when *plan participants* utilize *network* providers. These *networks* will be indicated on your *Plan* identification card. Services provided by *non-network* providers will not be eligible for the highest benefits. Specific benefit levels are shown in the **Schedule of Benefits**.

### Designated Coordinating Provider

All *plan participants* are asked to designate a coordinating *primary care provider (PCP)* for each *plan participants* of their family. While such designation is not mandatory, it is strongly recommended. To ensure highest level of benefits, and the best coordination of your care, all *plan participants* are encouraged to designate a *network primary care provider (PCP)* to be their coordinating provider. The Care Coordination process generally begins with the coordinating provider who maintains a relationship with the *plan participants*, provides general healthcare evaluation, guidance, and management.

*Plan participants* are encouraged to begin all healthcare events or inquiries with a call or visit to their designated *PCP* who will guide *plan participants* as appropriate. In addition to providing Care Coordination and submitting *pre-certification* requests, the *PCP* may also receive notices regarding healthcare services that their designated patients receive under the *Plan*. This allows the *PCP* to provide ongoing healthcare guidance.

If you have trouble obtaining access to a *PCP*, the Care Coordinators will be able to assist you by providing a list of *network PCPs*. Please contact the Care Coordinators by calling:

**Care Coordinators: 1.888.971.7377**

## C. Utilization Management

### Pre-Certification and Clinical Review

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

The following care, services, and procedures are subject to *pre-certification*:

1. *inpatient* and *skilled nursing facility* admissions
2. *outpatient surgeries*
3. MRI/MRA and PET scans
4. oncology care and services (chemotherapy, radiation therapy, clinical trials)
5. genetic testing
6. dialysis
7. organ, tissue, and bone marrow transplants
8. home health care
9. hospice care
10. durable medical equipment - all rentals and any purchase over $1500
11. *partial hospitalization* and intensive *outpatient* treatment for mental health/substance use disorders

All *pre-certification* and clinical review services are conducted by MyQHealth. Care Coordinators will assist *plan participants* in understanding what services require *pre-certification*.

**For *pre-certification*, providers should call the number listed on the Plan identification card.**

### Concurrent Utilization Review

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

### Personal Care Guide Management

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

During outreach, the personal care guide will touch on the *plan participant's* treatment and perform a physical assessment, perform a medication reconciliation to ensure there are no duplications or interactions, perform a depression screening with subsequent referrals to EAP or *network* providers, as well as focus on the physical and emotional needs of the *plan participant*.

The personal care guide will look at the *plan participant's* psychosocial needs and social determinants of health. In addition to the depression screening, they will evaluate the *plan participant's* financial issues, knowledge deficits, as

well as any cultural barriers that may exist. Conversations with the *plan participant* would occur at least monthly, if not more frequently, and continue until the *plan participant's* health goals and needs are met.

The primary personal care guide nurse will align with the *plan participant* and be the single point of contact them, and their family and caregivers, and providers.

The primary personal care guide nurse will:

1. provide comprehensive benefit education/utilization support
2. drive PCP designation and steerage to *network* providers
3. encourage provider involvement
4. deliver *pre-certification* assistance
5. perform pre-admission, pre-discharge, and post-discharge engagement
6. coordinate for utilization review and discharge planning
7. identify gaps in care and alleviate clinical, financial, and humanistic barriers
8. coordinate second opinions, drive utilization to other third-party vendor tools, and introduce community resources
9. perform behavioral health screening
10. our primary nurse model has three (3) foundational drivers for the changes:
    a. **Humanistic.** To help *plan participants* with acute and chronic needs by assigning a single nurse to the *plan participants* and their family as well as a heightened attention to psychosocial issues that can negatively affect health, quality of life, and financial outcomes.
    b. **Clinical.** Identify and prioritize members in need of clinical outreach. Improve adherence to quality measures for preventive health and management of chronic conditions.
    c. **Financial.** Identify and outreach to *plan participants* at risk for future high costs while encouraging preventive care and chronic condition management to improve health and reduce costs.

## D. General Provisions for Care Coordination

### Authorized Representative

The *plan participant* is ultimately responsible for ensuring that all *pre-certifications* are approved and in place prior to the time of service to receive the highest level of benefits. However, in most cases, the actual *pre-certification* process will be executed by the *plan participant's primary care provider* or other providers. By subscribing to this *Plan*, the *plan participant* authorizes the *Plan* and its designated service providers (including MyQHealth and the *Third Party Administrator*, and others) to accept healthcare providers or those providers who otherwise have knowledge of the *plan participant's* medical condition, as their *authorized representative* in matters of Care Coordination, including *pre-certification* requests. Communications with and notifications to such healthcare providers shall be considered as notification to the *plan participant*.

### Time of Notice

The *pre-certification* request should be made to the Care Coordinators within the following timeframe:

1. at least **three (3) business days,** before a scheduled (elective) *inpatient* admission
2. by the next business day after an emergency hospital admission
3. upon being identified as a potential organ or tissue transplant recipient
4. at least **three (3) business days** before receiving any other services requiring *pre-certification*

**For *pre-certification*, providers should call the number listed on the Plan identification card.**

**Special Note: The plan participant will not be penalized for failure to obtain *pre-certification* if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual**. However, *plan participants* who receive care on this basis must contact the Care Coordinators as soon as possible within twenty-four (24) hours of the first business day after receiving care or *hospital* admittance. Care Coordinators will then coordinate with MyQHealth Utilization Management to review services provided within forty-eight (48) hours of being contacted.

**Emergency Admissions and Procedures**

Any *inpatient* admission or *outpatient* procedure that has not been previously scheduled and cannot be delayed without harming the *plan participant's* health is considered an emergency for purposes of the Utilization Management notification.

**Maternity Admissions**

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

**Care Coordination is Not a Guarantee of Payment of Benefits**

The Care Coordination process does not provide a guarantee of payment of benefits. Approvals of *pre-certifications* for procedures, hospitalizations, and other services indicate that the medical condition, services, and care settings meet the utilization criteria established by the *Plan*. The Care Coordination approvals do not indicate that the service is a covered benefit, that the *plan participant* is eligible for such benefits, or that other benefit conditions such as co-*payments*, *deductibles*, *co-insurance*, or maximums have been satisfied. Final determinations regarding coverage and eligibility for benefits are made by the *Plan*.

**Appeal of Care Coordination Determinations**

*Plan participants* have certain appeal rights regarding adverse determinations in the Care Coordination process, including reduction of benefits and penalties. The appeal process is detailed in the **Claims and Appeals** section within this document.

# SECTION X—HINGE HEALTH

Hinge Health is an exercise therapy program that helps with muscle and joint pain. The program is tailored to a *plan participant's* specific needs and offers access to physical therapist, personal health coaching, convenient exercise therapy, and education articles to understand pain and treatment options. This program is available at no cost to *employees* and their *dependents* [eighteen (18) years and older] who are covered under the medical plan.

# SECTION XI—PRESCRIPTION DRUG BENEFITS

## A. About Your Prescription Benefits

The Prescription Drug Benefits are separate from the Medical Benefits and are administered by Navitus. This program allows you to use your Navitus *prescription drug* coverage at a nationwide *network* of participating *pharmacies* to purchase your prescriptions. When purchasing *prescription drugs* at retail *pharmacies* or through mail-order, using your ID card at participating *pharmacies* provides you with the best economic benefit.

If you purchase your *prescription drugs* from a *non-network pharmacy*, you will have to pay the full price of the prescription and then submit a *claim* for reimbursement. Reimbursement will be according to the *network* price, so your total out-of-pocket cost may likely be greater than the *co-insurance* you would have paid if you had used a *network pharmacy*.

*Claims* for non-network reimbursement of *prescription drugs* are to be submitted to Navitus using the Prescription Drug Claims Form and mailed to:

Navitus Health Solutions
ATTN: Commercial Claims
P.O. Box 999
Appleton, WI 54912-0999

**NOTE:** For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the Navitus Drug Coverage List, which is incorporated by reference and is available from your *employer* or MyQHealth Care Coordinators at 1.888.971.7377 or **https://client.formularynavigator.com/Search.aspx?siteCode=2055289521**.

## B. Co-Insurance

Once you have met the Medical Plan's *calendar year deductible*, your *co-insurance* is applied to each covered *pharmacy* drug or mail order drug charge and is shown in the Schedule of Prescription Drug Benefits. Any one (1) *pharmacy* prescription is limited to a thirty (30) day supply. Any one (1) mail order prescription is limited to a ninety (90) day supply.

## C. Manufacturer Coupons

Any amounts in the form of manufacturer coupons or drug savings discount cards used for brand name drugs do apply to the *out-of-pocket limit*.

## D. Mail Order Drug Benefit Option

Maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart *disease*, high blood pressure, asthma, etc.) should be obtained through the Mail Order program. If you do not use the Mail Order program after your second fill at a retail *pharmacy*, you will incur an additional $20 charge. Non-maintenance medications such as antibiotics and pain medications are excluded from this charge.

To initiate the mail order drug benefit option, complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your *physician*, or have your *physician* phone or fax the prescription to the Worthington Industries Pharmacy. For more information, call the Worthington Pharmacy at 1.800.944.4515. If you reside in a state where the Worthington Industries Pharmacy is not licensed, you may use Navitus Home Delivery by calling 1.888.240.2211. You will need to submit the applicable *co-insurance* and/or *deductible* when you request a prescription or refill.

If certain supplies, equipment, or appliances are not obtained by the mail order pharmacy or from a *network* pharmacy then they are covered as medical supplies, equipment, and appliances instead of under Prescription Drug benefits.

## E. Specialty Pharmacy Program

The Specialty Pharmacy Program covers some limited drugs, such as specialty injectables, cancer drugs, and certain respiratory therapies used to treat various chronic conditions. Your first fill of a Specialty Medication may be obtained at a refill pharmacy but refills must come from the Worthington Industries Pharmacy or Lumicera, the Navitus Specialty Pharmacy. For more information on Specialty Medications, call the Worthington Industries Pharmacy at 1.800.944.4515 or Lumicera at 1.855.847.3553.

### F. Prior Authorization

Prescriptions for certain medications or circumstances require clinical approval before they can be filled, even with a valid prescription. Prescriptions may be limited to quantity, frequency, dosage, or may have age restrictions. If prior authorization is not approved, the designated drug will not be eligible for coverage. The authorization process may be initiated by the *plan participant*, the local *pharmacy*, or the *physician* by calling Navitus at 1.855.673.6504.

### G. Medicare Part D Prescription Drug Plans for Medicare Eligible Participants

*Plan participants* enrolled in either Part A or Part B of *Medicare* are also eligible for *Medicare* Part D Prescription Drug benefits. It has been determined that the *prescription drug* coverage provided in this *Plan* is generally better than the standard *Medicare* Part D Prescription Drug benefits. Because this *Plan's prescription drug* coverage is considered creditable coverage, you do not need to enroll in *Medicare* Part D to avoid a late penalty under *Medicare*. If you enroll in *Medicare* Part D while covered under this *Plan*, payment under this *Plan* may coordinate benefit payment with *Medicare*. Refer to the **Coordination of Benefits** section of the *Plan* for information on how this *Plan* will coordinate benefit payment.

### H. Covered Prescription Drug Charges

1. **Abortion.** Drugs that induce abortion such as Mifepristone (RU-486).
2. **Botox.** Botox injections when administered for an otherwise covered condition, up to four hundred (400) milligrams per dose.
3. **Compounded Prescription Drugs.** Compound drugs containing at least one (1) prescription ingredient in a therapeutic quantity when a commercially available dosage form of a *medically necessary* medication is not available, all the ingredients of the compound drug are FDA-approved and require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
4. **Diabetic.** Insulin, continuous blood glucose monitor, and other diabetic supplies when prescribed by a *physician*.
5. **Impotence.** Charges for impotence medication will be limited to six (6) units per thirty (30) days or eighteen (18) units per ninety (90) days.
6. **Injectable Drugs.** Injectable drugs or any prescription directing administration by injection.
7. **Oral Contraceptives.** Certain contraceptives are covered under the Preventive Care provisions.
8. **Prescribed by Physician.** All drugs prescribed by a *physician* that require a prescription either by federal or state law.

   This excludes any drugs stated as not covered under this *Plan*.
9. **Prescription Drugs mandated under PPACA.** Certain preventive medications (including contraceptives) received by a *network pharmacy* are covered and subject to the following limitations:
   a. generic preventive *prescription drugs* are covered at 100%, and the *deductible/co-insurance* (if applicable) is waived
   b. if no *generic drug* is available, then the *preferred brand* will be covered at 100%, and the *deductible/ co-insurance* (if applicable) is waived

   This provision includes, but is not limited to, the following categories of drugs (In order for these medications to be covered at 100%, a prescription is required from your *physician*, including over-the-counter drugs.):
   a. **Breast Cancer Risk-Reducing Medications.** Medications such as tamoxifen or raloxifene for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
   b. **Contraceptives**. Women's contraceptives including, but not limited to, oral contraceptives, transdermal contraceptives (i.e., Ortho-Evra), vaginal rings (i.e., Nuvaring), implantable contraceptive devices, injectable contraceptives, and *emergency* contraception.

c. **Immunizations.** Certain vaccinations are available without cost sharing including vaccines for influenza, pneumonia, tetanus, hepatitis, shingles, measles, mumps, HPV (human papillomavirus), pertussis, varicella, and meningitis.

d. **Over-the-Counter Prescriptions.** Limited to only those items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a *physician*, including the following:

1. aspirin
2. folic acid supplement
3. vitamin D supplement
4. iron supplement
5. bowel preparations

Certain age and gender and quantity limitations apply.

e. **Preparation 'Prep' Products for a Colon Cancer Screening Test.** The *Plan* covers the over-the-counter or prescription strength products prescribed as preparation for a payable preventive colon cancer screening test, such as a colonoscopy.

f. **Tobacco Cessation Products**. Such as nicotine gum, smoking deterrent patches, or generic tobacco cessation medications. These drugs and over-the-counter products are payable without cost sharing up to a one hundred eighty (180) day supply per three hundred sixty-five (365) days. Thereafter, the applicable *co-payment/co-insurance* applies.

Please refer to the following website for information on the types of payable preventive medications: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**.

10. **Self-Administered Drugs.**
11. **Specialty Drugs.**

### I. Limits to This Benefit

This benefit applies only when a *plan participant incurs* a covered *prescription drug* charge. The covered drug charge for any one (1) prescription will be limited to:

1. refills only up to the number of times specified by a *physician*
2. refills up to one (1) year from the date of order by a *physician*

The *Plan* may, in its sole discretion, establish quantity and/or age limitations for specific *prescription drugs* which Navitus will administer. *Covered charges* will be limited based on *medical necessity*, quantity, and/or age limits established by the *Plan* or utilization guidelines.

In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases the *Plan* may approve an early refill. If you are going on vacation and you need more than the allowed supply, ask your pharmacist to call Navitus and ask for an override for one (1) early refill. If you need more than one (1) early refill, please call MyQHealth Care Coordinators.

The *Claims Administrator* retains the right, at the *Claims Administrator's* discretion, to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical, or inhaled) and may cover one form of administration and exclude other forms of administration.

### J. Dispense As Written (DAW) Program

The *Plan* requires that retail *pharmacies* dispense *generic drugs* when available. Should a *plan participant* choose a preferred *formulary* brand or non-preferred *formulary* drug rather than the generic equivalent, the *plan participant* will be responsible for the *co-insurance* for the brand-name drug outlined in the **Schedule of Benefits**. When a *physician* orders a drug to be 'dispensed as written (DAW),' a preferred or non-preferred brand drug may be dispensed in lieu of the generic equivalent. The *plan participant* will pay the applicable *co-insurance* for the brand-name drug as outlined in the **Schedule of Benefits**.

**K. Prescription Drug Plan Exclusions**

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

1. **Administration.** Any charge for the administration of a covered *prescription drug*.
2. **Appetite Suppressants/Dietary Supplements.** A charge for appetite suppressants, dietary supplements, or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
3. **Clinical Equivalent.** Certain *prescription drugs* may not be covered when clinically equivalent alternatives are available, unless otherwise required by law. "Clinically equivalent" means drugs that, for the majority of *plan participants*, can be expected to produce similar therapeutic outcomes for a disease or condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call MyQHealth Care Coordinators.
4. **Compound Drugs.** Compound drugs unless all of the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles, and/or pharmaceutical adjuvants.
5. **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
6. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
7. **Drugs Used for Cosmetic Purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A, treatment of onychomycosis (toenail fungus), or medications for hair growth or removal.
8. **Experimental/Investigational.** E*xperimental/investigational* drugs and medicines, even though a charge is made to the *plan participant*. A drug or medicine labeled: "Caution: Federal law prohibits dispensing without prescription."
9. **FDA.** Any drug not approved by the Food and Drug Administration.
10. **Gene Therapy.** Any drugs, procedures, or health care services related to gene therapy that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
11. **Growth Hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance, unless preauthorized through the pharmacy benefit manager.
12. **Immunization.** Immunization agents or biological sera.
13. **Infertility.** A charge for *infertility* medication.
14. **Inpatient Medication.** A drug or medicine that is to be taken by the *plan participant*, in whole or in part, while *hospital* confined. This includes being confined in any *institution* that has a facility for the dispensing of drugs and medicines on its premises.
15. **Medical Exclusions.** A charge excluded under the Medical Plan Exclusions subsection, unless specifically covered in this **Prescription Drug Benefits** section.
16. **No Charge.** A charge for *prescription drugs* which may be properly received without charge under local, state, or federal programs.
17. **No Prescription Required.** Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except for injectable insulin
18. **Non-Legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
19. **Over-the-Counter.** Drugs, devices, products, or prescription legend drugs with over-the-counter equivalents and any drugs, devices, or products that are therapeutically comparable to an over-the-counter drug, device, or product. This exclusion does not apply to over-the-counter products that the *Plan* must cover under federal law with a prescription.
20. **Refills.** Any refill that is requested more than one (1) year after the prescription was written or any refill that is more than the number of refills ordered by the *physician*.

# SECTION XII—CLAIMS AND APPEALS

This section contains the *claims* and *appeals* procedures and requirements for the Worthington Industries Group Welfare Plan.

**TIME LIMIT FOR FILING CLAIMS**

All *claims* must be received by the *Plan* within twelve (12) months from the date of *incurring* the expense, or in accordance with applicable federal government regulations. The *Plan* will accept *network* adjustments of *claims* that are within the *network's* established guidelines.

The *Plan's* representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit *claim* determinations are made in accordance with governing plan documents and that where appropriate the *Plan* provisions have been applied consistently with respect to similarly situated *claimants*.

The following types of *claims* are covered by the procedures in this section:

1. **Pre-Service Claim.** Some *Plan* benefits are payable only if the *Plan* approves services **before** services are rendered. These benefits are referred to as *pre-service claims* (also known as *pre-certification* or prior authorization). The services that require *pre-certification* are listed in the **Care Coordination Program** section of this document.
2. **Urgent Care Claim.** An *urgent care claim* is a *claim* (request) for medical care or treatment in which:
    a. applying the time periods for *pre-certification* could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function
    b. in the opinion of a *physician* with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*
    c. the *claim* involves urgent care
3. **Concurrent Care Claim.** A *concurrent care claim* refers to a *Plan* decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A *concurrent care claim* also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.
4. **Post-Service Claim.** *Post-service claims* are *claims* that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard *claim* and an electronic bill, submitted for payment after services have been provided, are examples of *post-service claims*. A *claim* regarding rescission of coverage will be treated as *post-service claim*.

Following is a description of how the *Plan* processes *claims* for benefits and reviews the *appeal* of any *claim* that is denied.

If a *claim* is denied, in whole or in part, or if *Plan* coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an *adverse benefit determination*.

A *claimant* has the right to request a review of an *adverse benefit determination*. This request is an *appeal*. If the *claim* is denied at the end of the *appeal* process, as described later in this section, the *Plan's* final decision is known as a *final internal adverse benefit determination*. If the *claimant* receives *notice* of a *final internal adverse benefit determination*, or if the *Plan* does not follow the *appeal* procedures properly, the *claimant* then has the right to request an independent *external review*. The *external review* procedures are also described later in this section.

Both the *claims* and the *appeal* 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.

A *claimant* must follow all *claims* and *appeals* procedures, both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the *Plan Administrator* has not complied with the procedures described in this section. If a lawsuit is brought, it must be filed within two (2) years after the final determination of an *appeal*.

Any of the authority and responsibilities of the *Plan Administrator* under the *claims* and *appeals* procedures or the *external review* process, including the discretionary authority to interpret the terms of the *Plan*, may be delegated to a third party. If you have any questions regarding these procedures, please contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

## A. Timeframes for Claim and Appeal Processes

| | Post-Service Claims | Pre-Service Claim Types | | |
|---|---|---|---|---|
| | | Urgent Care Claim | Concurrent Care Claim | Other Pre-Service Claim |
| *Claimant* must submit *claim* for benefit determination within: | twelve (12) months | twenty-four (24) hours | | |
| *Plan* must make initial *benefit determination* as soon as possible but no later than: | thirty (30) days | seventy-two (72) hours | before the benefit is reduced or treatment terminated | fifteen (15) days |
| Extension permitted during initial *benefit determination*: | fifteen (15) days | no | no | fifteen (15) days |
| First-level *appeal* review must be submitted to the *Plan* within: | one hundred eighty (180) days | one hundred eighty (180) days | one hundred eighty (180) days | one hundred eighty (180) days |
| *Plan* must make first *appeal benefit determination* as soon as possible but no later than: | sixty (60) days per benefit *appeal* | seventy-two (72) hours | before the benefit is reduced or treatment terminated | thirty (30) days for each level of *appeal* |
| Extension permitted during *appeal* review: | no | no | no | no |
| Appeal for external review must be submitted after a final adverse benefit determination within: | four (4) months | four (4) months | four (4) months | four (4) months |
| *Plan* will complete preliminary review of *IRO* request within: | five (5) business days | five (5) business days | five (5) business days | five (5) business days |
| *Plan* will *notify claimant* of preliminary review within: | one (1) business day | one (1) business day | one (1) business day | one (1) business day |
| *IRO* determination and *notice* within: | forty-five (45) days | seventy-two (72) hours | seventy-two (72) hours | forty-five (45) days |

## B. Types of Claims Managed by MyQHealth Care Coordinators

The following types of *claims* are managed by MyQHealth Care Coordinators:

1. *urgent care claims*
2. *concurrent care claims*
3. other *pre-service claims*

The process and procedures for each *pre-service claim* type are listed below.

## C. Urgent Care Claims

Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an *urgent care claim* will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any *claim* that a *physician*, with knowledge of the *claimant's* medical condition, determines is an *urgent care claim* (as described herein) shall be treated as an *urgent care claim* under the *Plan*. *Urgent care claims* are a subset of *pre-service claims*.

### How to File Urgent Care Claims

In order to file an *urgent care claim*, you or your *authorized representative* must call MyQHealth Care Coordinators and provide the following:

1. information sufficient to determine whether, or to what extent, benefits are covered under the *Plan*
2. a description of the medical circumstances that give rise to the need for expedited review

If you or your *authorized representative*s fail to provide the *Plan* with the above information, the *Plan* will provide *notice* as soon as reasonably possible after receipt of your *claim*, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. You will be afforded a reasonable amount of time to provide the specified information under the circumstance, but not less than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection.

**Notification of Benefit Determination of Urgent Care Claims**

*Notice* of a *benefit determination* (whether adverse or not) will be provided as soon as possible, taking into account the medical circumstances, but no later than the deadline shown in the Timeframes for Claim and Appeal Processes subsection. However, if the *Plan* gives you *notice* of an incomplete *claim*, the *notice* will include a time period of no less than forty-eight (48) hours for you to respond with the requested specified information. The *Plan* will then provide you with the *notice* of *benefit determination* within forty-eight (48) hours after the earlier of:

1. receipt of the specified information
2. the end of the period of time given you to provide the information

If the *benefit determination* is provided orally, it will be followed in writing no later than three (3) days after the oral *notice*.

If the *urgent care claim* involves a *concurrent care decision*, a *notice* of the *benefit determination* (whether adverse or not) will be provided as soon as possible after receipt of your *claim* for extension of treatment or care, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection, as long as the *claim* is made within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection before the prescribed period of time expires or the prescribed number of treatments ends.

**Notification of Adverse Benefit Determination of Urgent Care Claims**

If an *urgent care claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator's notification* of an *adverse benefit determination* may be oral, followed by written or electronic *notification* within three (3) days of the oral *notification*. The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the expedited review process applicable to the *claim*
8. a description of the *Plan's* review or *appeal* procedures, including applicable time limits, and a statement of your right to bring suit under ERISA §502(a) with respect to any *claim* denied after an *appeal*
9. information about the availability of and contact information for any 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* process

**How to File an Appeal of an Urgent Care Claim**

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole fiduciary of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes subsection for when a *claimant* may file a written request for an *appeal* to the decision upon *notification* of an *adverse benefit determination*. However, for concurrent care *claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within the timeframe shown

in the Timeframes for Claim and Appeal Processes subsection. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* or its designee will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* or its designee written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Plan Administrator* or its designee will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Plan Administrator* or its designee issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

**Form and Timing of Appeals of Denied Urgent Care Claims**

You or your *authorized representative* must file any *appeal* of an *adverse benefit determination* after receiving notification of the *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection.

Requests for *appeal* which do not comply with the above requirement will not be considered.

You may *appeal* an *adverse benefit determination* of an *urgent care claim* on an expedited basis, either orally or in writing. You may *appeal* orally by calling MyQHealth Care Coordinators at 1.888.971.7377. All necessary information, including MyQHealth Care Coordinators' *benefit determination* on review, will be transmitted between MyQHealth Care Coordinators and you by telephone, facsimile, or other available similarly expeditious method.

**Time Period for Deciding Appeals of Urgent Care Claims**

*Appeals* of *urgent care claims* will be decided by the *Plan Administrator* or its designee as soon as possible after the *Plan Administrator* or its designee receives the *appeal*, taking into account the *medical emergencies*, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. A decision communicated orally will be followed-up in writing.

**Notification of Appeal Denials of Urgent Care Claims**

The *Plan Administrator* or its designee shall provide *notification* of the decision on an *urgent care claim* orally, but a follow-up written *notification* after the oral *notice* will be provided no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The *notice* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One (1) way to find out what may be available is to contact your local U.S. Department of Labor Office.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational*, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request
7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures, and a statement of your right to bring suit under *ERISA* §502(a)
10. information about the availability of and contact information for any 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* process

**D. Concurrent Care Claims**

Your *claim* for medical care or treatment is a *concurrent care claim* if your *claim* has been approved to provide an ongoing course of treatment over a period of time, which either involves a reduction or termination by the *Plan* of such course of treatment (other than by *Plan* amendment or termination), or a request by you or on your behalf to extend or expand your treatment.

If your request involves concurrent care (the continuation/reduction of an ongoing course of treatment), you may file the *claim* by writing (orally for an expedited review) to MyQHealth Care Coordinators.

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided *notification* of the termination or reduction sufficiently in advance of the reduction or termination to allow you to *appeal* and obtain a determination of that *adverse benefit determination* before the benefit is reduced or terminated.
2. The *Plan* will provide you free of charge with any new or additional evidence considered, relied upon, or generated by the *Plan* (or at the direction of the *Plan*) in connection with the denied *claim*. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the *notice* of *adverse benefit determination* on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the *Plan* issues an *adverse benefit determination* or review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the *notice* of *adverse benefit determination* on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

3. A *concurrent care claim* that involves urgent care will be processed according to the initial review and *appeals* procedures and timeframes noted under the Urgent Care Claims subsection (above).
4. If a *concurrent care claim* does not involve urgent care, the request may be treated as a new benefit *claim* and decided within the timeframe appropriate to the type of *claim* (i.e., as a *pre-service claim* or a *post-service claim*). Such *claims* will be processed according to the initial review and *appeals* procedures and timeframes applicable to the claim-type, as noted under the Other Pre-Service Claims subsection (below) or the Post-Service Claims subsection listed later in this section.

   If the *concurrent care claim* is approved, you will be *notified* orally followed by written (or electronic, as applicable) *notice* provided after the oral *notice* no later than the timeframe shown in the Timeframes for Claim and Appeal Processes.

### E. Other Pre-Service Claims

*Claims* that require *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* are considered *other pre-service claims* (e.g. a request for *pre-certification* under the Care Coordination Program). Refer to the **Heath Care Management Program** section to review the list of services that require *pre-certification*.

#### How to File Other Pre-Service Claims

Typically, other *pre-service claims* are made on a *claimant's* behalf by the treating *physician*. However, it is the *claimant's* responsibility to ensure that the other *pre-service claim* has been filed. The *claimant* can accomplish this by having his or her health care provider contact MyQHealth Care Coordinators to file the *other pre-service claim* on behalf of the *claimant*.

Other *pre-service claims* must include the following information:

1. the name of this *Plan*
2. the identity of the *claimant* (name, address, and date of birth)
3. the proposed date(s) of service
4. the name and credentials of the health care provider
5. an order or request from the health care provider for the requested service
6. the proposed place of service
7. a specific diagnosis
8. a specific proposed service code for which approval or payment is requested [current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format]
9. clinical information for this *Plan* to make a *medical necessity* determination

Under certain circumstances provided by federal law, if you or your *authorized representative* fail to follow the *Plan's* procedures for filing other *pre-service claims*, the *Plan* will provide *notice* of the failure and the proper procedures to be followed. This *notification* will be provided as soon as reasonably possible, but no later than five (5) days after receipt of the *claim*. You will then have up to forty-five (45) days from receipt of the *notice* to follow the proper procedures.

#### Notification of Benefit Determination of Other Pre-Service Claims

After receipt of the *claim, notice* of a *benefit determination* (whether adverse or not) will be provided in writing within a reasonable period appropriate to the medical circumstances, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. However, this period may be extended one (1) time by the *Plan* for up to an additional fifteen (15) days if the *Plan* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original timeframe shown in the Timeframes for Claim and Appeal Processes subsection, of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision. Refer to the Incomplete Claims subsection below if such an extension is necessary due to your failure to submit the information necessary to decide the *claim*.

**Notification of Adverse Benefit Determination of Other Pre-Service Claims**

If the other *pre-service claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator* or its designee shall provide written or electronic *notification* of the *adverse benefit determination*. This *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the *Plan's* review or *appeal* procedures, including applicable time limits, and a statement of your right to bring suit under *ERISA* §502(a) with respect to any *claim* denied after an *appeal*
8. information about the availability of and contact information for any 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* process

**How to File an Appeal of Other Pre-Service Claims**

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole fiduciary of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes subsection in which a *claimant* may file a written request for an *appeal* of the decision after receiving *notification* of an *adverse benefit determination*. However, for concurrent care *claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within thirty (30) days. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* or its designee will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s), and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* or its designee written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Plan Administrator* or its designee will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*

4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Plan Administrator* or its designee issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

**Form and Timing of Appeals of Other-Pre-Service Claims**

You or your *authorized representative* must file any *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection after receiving notification of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirement will not be considered.

All requests for a review of a denied *pre-service claim* (other than *urgent care claim*) must be in writing and should include a copy of the *adverse benefit determination*, if applicable, and any other pertinent information that you wish MyQHealth Care Coordinators to review in conjunction with your *appeal*. Send all information to the *Medical Management Administrator* as listed in the Quick Reference Information Chart.

**Time Period for Deciding Appeals of Other Pre-Service Claims**

*Appeals* of other *pre-service claims* will be decided by the *Plan Administrator* or its designee within a reasonable period of time appropriate to the medical circumstances, after the *Plan Administrator* or its designee receives the *appeal*, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The *Plan Administrator* or its designee*'s* decision will be provided to you in writing.

**Notification of Appeal Denials of Other Pre-Service Claims**

If your *appeal* is denied, in whole or in part, the *Plan Administrator* or its designee will provide written *notification* of the *adverse benefit determination* on *appeal*. The *notice* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   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.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational*, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan*

to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request

7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures, and a statement of your right to bring suit under *ERISA* §502(a)
10. information about the availability of and contact information for any 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* process

### F. Voluntary Second Level Appeals Process for Urgent Care, Concurrent Care, and Other Pre-Service Claims

If your *appeal* of a *claim* is denied, you or your *authorized representative* may request further review by the *Plan Administrator*. This request for a second-level *appeal* must be made in writing within sixty (60) days of the date you are *notified* of the original *appeal* decision. For *claims*, this second-level review is voluntary. Send all information to:

Worthington Industries, Inc.
ATTN: Benefits Department
200 Old Wilson Bridge Road
Columbus, OH 43085
1.877.840.6506

The *Plan Administrator* or its designee will promptly conduct a full and fair review of your *appeal*, independently from the individual(s) who considered your first-level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the *adverse benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

Second-level *appeals* of *claims* will be decided by the *Plan Administrator* or its designee within a reasonable period of time, but no later than fifteen (15) days after the *Plan Administrator* or its designee receives the *appeal*. The *Plan Administrator* or its designee's decision will be provided to you in writing, and if the decision is a second denial, the *notification* will include all of the information described in the subsection entitled Notification of Appeal Denials above.

### G. External Review of Pre-Service Claims

Refer to the **External Review of Claims** section for the full description of the *external review* process under the *Plan*.

### H. Incomplete Claims

Incomplete *pre-service claims* and/or *post-service claims* can be addressed through the extension of time described herein. If the reason for the extension is the failure to provide necessary information and the *claimant* is appropriately *notified*, this *Plan's* period of time to make a decision is suspended from the date upon which *notification* of the missing necessary information is sent until the date upon which the *claimant* responds or should have responded.

The *notification* will include a timeframe of at least forty-five (45) days in which the necessary information must be provided. Once the necessary information has been provided, this *Plan* will decide the *claim* within the extension described herein.

However, if the time period for the *benefit determination* is extended due to your failure to submit information necessary to decide a *claim*, the time period for making the *benefit determination* will be suspended from the date the *notice* of extension is sent to you until the earlier of:

1. the date on which you respond to the request for additional information
2. the date established by the *Plan* for the furnishing of the requested information [at least forty-five (45) days]

If the requested information is not provided within the time specified, the *claim* may be denied. If your *claim* is denied based on your failure to submit information necessary to decide the *claim*, the *Plan* may, in its sole discretion, renew its consideration of the denied *claim* if the *Plan* receives the additional information within one hundred eighty (180) days after original receipt of the *claim*. In such circumstances, you will be *notified* of the *Plan's* reconsideration and subsequent *benefit determination*.

## I. Post-Service Claims

MyQHealth Care Coordinators manage the *claims* and first-level *appeal* process of *post-service claims*.

*Post-service claims* are *claims* that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard *claim* and an electronic bill, submitted for payment after services have been provided, are examples of *post-service claims*. A *claim* regarding rescission of coverage will be treated as *post-service claim*.

### How to File Post-Service Claims

All *claims* must be received by the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection from the date of the expense and must include the following information:

1. the *plan participant's* name, Social Security Number, and address
2. the covered *employee's* name, Social Security Number, and address if different from the *plan participant's*
3. the provider's name, tax identification number, address, degree, and signature
4. date(s) of service
5. diagnosis
6. procedure codes (describes the treatment or services rendered)
7. *assignment of benefits*, signed (if payment is to be made to the provider)
8. release of information statement, signed
9. coordination of benefits (COB) information if another plan is the primary payer
10. sufficient medical information to determine whether and to what extent the expense is a covered benefit under the *Plan*

Send complete information to your local BlueCross BlueShield office.

### Notification of Benefit Determination of Post-Service Claims

After receipt of the *claim*, the *Plan* will *notify* you or your *authorized representative* of its *benefit determination* (whether adverse or not) no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. However, this period may be extended one (1) time by the *Plan* for up to the timeframe shown in the Timeframes for Claim and Appeal Processes subsection if the *Plan* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original period, of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision.

The applicable time period for the *benefit determination* begins when your *claim* is filed in accordance with the reasonable procedures of the *Plan*, even if you haven't submitted all the information necessary to make a *benefit determination*. Refer to the Incomplete Claims subsection for information regarding incomplete *claims*.

### Notification of Adverse Benefit Determination of Post-Service Claims

If a *post-service claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator* or its designee shall provide written or electronic *notification* of the *adverse benefit determination*. This *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request

2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the *Plan's* review or *appeal* procedures, including applicable time limits, and a statement of your right to bring suit under *ERISA* §502(a) with respect to any *claim* denied after an *appeal*
8. information about the availability of and contact information for any 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* process

**How to File an Appeal of Post-Service Claims**

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole fiduciary of the *Plan*, and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes subsection in which a *claimant* may file a written request for an *appeal* of the decision. However, for *concurrent care claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* or its designee will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* or its designee written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Plan Administrator* or its designee will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Plan Administrator* or its designee issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

**Form and Timing of Appeals of Denied Post-Service Claims**

You or your *authorized representative* must file any *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection after receiving notification of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirement will not be considered.

All requests for a review of a denied *post-service claim* must be in writing and should include a copy of the *adverse benefit determination* and any other pertinent information that you wish MyQHealth Care Coordinators to review in conjunction with your *appeal*. Send all information to:

MyQHealth Care Coordinators
7450 Huntington Park Drive
Columbus, OH 43235
1.888.971.7377

**Time Period for Deciding Appeals of Post-Service Claims**

*Appeals* of *post-service claims* will be decided by the *Plan Administrator* or its designee within a reasonable period of time after the *Plan Administrator* or its designee receives the *appeal*, but not later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The *Plan Administrator* or its designee*'s* decision will be provided to you in writing.

**Notification of Appeal Denials of Post-Service Claims**

If your *appeal* is denied, in whole or in part, the *Plan Administrator* or its designee will provide written *notification* of the *adverse benefit determination* on *appeal*. The *notice* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One (1) way to find out what may be available is to contact your local U.S. Department of Labor Office.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational*, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request
7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures

9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures, and a statement of your right to bring suit under *ERISA* §502(a)
10. information about the availability of and contact information for any 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* process

### J. Voluntary Second-Level Appeal Process of Post-Service Claims

The *Plan Administrator* or its designee manages the second-level *appeal* process for *post-service claim* decisions.

The *Plan Administrator* or its designee will be identified in the *notification* of denial of your first-level *appeal* and will not be the individual who made the original decision regarding the denial of your first-level *appeal* or a subordinate of such individual.

If your *appeal* of a *post-service claim* is denied, you or your *authorized representative* may request further review by the *Plan Administrator* or its designee. This request for a second-level *appeal* must be made in writing within sixty (60) days of the date you are *notified* of the original *appeal* decision. For *claims*, this second-level review is voluntary. Send all information to:

Worthington Industries, Inc.
ATTN: Benefits Department
200 Old Wilson Bridge Road
Columbus, OH 43085
1.877.840.6506

The *Plan Administrator* or its designee will promptly conduct a full and fair review of your *appeal*, independently from the individual(s) who considered your first-level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information, as described in more detail under the subsection entitled Post-Service Claims above.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the *adverse benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

Second-level *appeals* of *post-service claims* will be decided by the *Plan Administrator* or its designee within a reasonable period of time, but no later than thirty (30) days after the *Plan Administrator* or its designee receives the *appeal*. The *Plan Administrator* or its designee's decision will be provided to you in writing, and if the decision is a second denial, the *notification* will include all of the information described in the provision entitled Notification of Appeal Denials of Post-Service Claims above.

### K. External Review Rights

If your final *appeal* for a *claim* is denied, you will be *notified* in writing that your *claim* is eligible for an *external review*, and you will be informed of the time frames and the steps necessary to request an *external review*. You must complete all levels of the internal *claims* and *appeals* procedures before you can request a voluntary *external review*.

If you decide to seek *external review*, an *independent review organization (IRO)* will be assigned your *claim*, and the *IRO* will work with a neutral, independent clinical reviewer with appropriate medical expertise. The *IRO* does not have to give deference to any earlier *claims* and *appeals* decisions, but it must observe the written terms of the summary plan description. In other words, the *IRO* is not bound by any previous decision made on your *claim*. The ultimate decision of the *IRO* will be binding on you, the *Claims Administrator*, and the *Plan*.

### L. External Review of Claims

The *external review* process is available only where the *final internal adverse benefit determination* is denied on the basis of any of the following:

1. a medical judgment (which includes but is not limited to: *Plan* requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit)

2. a determination that a treatment is *experimental* or *investigational*
3. a rescission of coverage

If your *appeal* is denied, you or your *authorized representative* may request further review by an *Independent Review Organization (IRO)*. This request for *external review* must be made, in writing, within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection beginning the date you are notified of an *adverse benefit determination* or *final internal adverse benefit determination*. This *external review* is mandatory, i.e., you are required to undertake this *external review* before you may pursue civil action under Section 502(a) of ERISA.

The *Plan* will complete a preliminary review of the request within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection following the date of the receipt of the *external review* request to determine whether:

1. 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
2. the *adverse benefit determination* or the *final internal adverse benefit determination* does not relate to the *claimant's* failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination)
3. the *claimant* has exhausted the *Plan's* internal *appeal* process
4. the *claimant* has provided all the information and forms required to process an *external review*

The *Plan* will *notify* the *claimant* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection of completion of its preliminary review if either :

1. the request is complete but not eligible for *external review*, in which case the *notice* will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration [toll-free number 1.866.444.EBSA (3272)]
2. the request is not complete, in which case the *notice* will describe the information or materials needed to make the request complete, and allow the *claimant* to perfect the request for *external review* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection, or within the forty-eight (48) hour period following receipt of the *notification*, whichever is later

**NOTE:** If the *adverse benefit determination* or *final internal adverse benefit determination* relates to a *plan participant's* or beneficiary's failure to meet the requirements for eligibility under the terms of the *Plan*, it is not within the scope of the *external review* process, and no *external review* may be taken.

If the request is complete and eligible, the *Plan Administrator* or its designee will assign the request to an *IRO*. Once that assignment is made, the following procedure will apply:

1. The assigned *IRO* will utilize legal experts where appropriate to make coverage determinations under the *Plan*.
2. The assigned *IRO* will timely *notify* the *claimant* in writing of the request's eligibility and acceptance for *external review*. This *notice* will include a statement that the *claimant* may submit in writing to the assigned *IRO*, within ten (10) business days following the date of receipt of the *notice*, additional information that the *IRO* must consider when conducting the *external review*. The *IRO* is not required to, but may, accept and consider additional information submitted after ten (10) business days.
3. Within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection after the date of assignment of the *IRO*, the *Plan* must provide to the assigned *IRO* the documents and any information considered in making the *adverse benefit determination* or *final internal adverse benefit determination*. Failure by the *Plan* to timely provide the documents and information must not delay the conduct of the *external review*. If the *Plan* fails to timely provide the documents and information, the assigned *IRO* may terminate the *external review* and make a decision to the *adverse benefit determination* or *final internal adverse benefit determination*. The *IRO* must *notify* the *claimant* and the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection after making the decision.
4. Upon receipt of any information submitted by the *claimant*, the assigned *IRO* must forward the information to the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. Upon receipt of any such information, the *Plan* may reconsider its *adverse benefit determination* or *final internal adverse benefit determination* that is the subject of the *external review*. Reconsideration by the *Plan* must not delay the *external review*. The *external review* may be terminated as a result of the reconsideration only if the *Plan* decides, upon completion of its reconsideration, to reverse its *adverse benefit determination* or *final internal adverse benefit determination* and provide coverage or payment. The *Plan* must provide written

*notice* of its decision to the *claimant* and the assigned *IRO* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The assigned *IRO* must terminate the *external review* upon receipt of the *notice* from the *Plan*.

5. The *IRO* will review all of the information and documents timely received. In reaching a decision, the assigned *IRO* will review the *claim* de novo and not be bound by any decisions or conclusions reached during the *Plan's* internal *claims* and *appeals* process. In addition to the documents and information provided, the assigned *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, will consider the following in reaching a decision:
    a. the *claimant's* medical records
    b. the attending health care professional's recommendation
    c. reports from appropriate health care professionals and other documents submitted by the *Plan*, *claimant*, or the *claimant's* treating provider
    d. the terms of the *claimant's Plan* to ensure that the *IRO's* decision is not contrary to the terms of the *Plan*, unless the terms are inconsistent with applicable law
    e. appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations
    f. any applicable clinical review criteria developed and used by the *Plan*, unless the criteria are inconsistent with the terms of the *Plan* or with applicable law
    g. the opinion of the *IRO's* clinical reviewer or reviewers after considering the information described in this *notice* to the extent the information or documents are available
6. The assigned *IRO* must provide written *notice* of the final *external review* decision after the *IRO* receives the request for the *external review* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The *IRO* must deliver the *notice* of final *external review* decision to the *claimant* and the *Plan*.
7. The assigned *IRO's* decision *notice* will contain:
    a. a general description of the reason for the request for *external review*, including information sufficient to identify the *claim* [including the date or dates of service, the health care provider, the *claim* amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial]
    b. the date the *IRO* received the assignment to conduct the *external review* and the date of the *IRO* decision
    c. the references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision
    d. a discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision
    e. a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health *Plan* or to the *claimant*
    f. a statement that judicial review may be available to the *claimant*
    g. current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman

If you remain dissatisfied with the outcome of the *external review*, you may pursue civil action under Section 502(a) of ERISA.

Generally, a *claimant* must exhaust the *Plan's claims* and *appeals* procedures in order to be eligible for the *external review* process. However, in some cases the *Plan* provides for an expedited *external review* if either:

1. The *claimant* receives an *adverse benefit determination* that involves a medical condition for which the time for completion of the *Plan's* internal *claims* and *appeals* procedures would seriously jeopardize the *claimant's* life, health, or ability to regain maximum function, and the *claimant* has filed a request for an expedited internal review.
2. The *claimant* receives a *final internal adverse benefit determination* that involves a medical condition where the time for completion of a standard *external review* process would seriously jeopardize the *claimant's* life or health or the *claimant's* ability to regain maximum function, or if the *final 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.

Immediately upon receipt of a request for expedited *external review*, the *Plan* must determine and *notify* the *claimant* whether the request satisfies the requirements for expedited review, including the eligibility requirements for *external review* listed above. If the request qualifies for expedited review, it will be assigned to an *IRO*. The *IRO* must make its determination and provide a *notice* of the decision as expeditiously as the *claimant's* medical condition or circumstances require after the *IRO* receives the request for an expedited *external review*, but in no event more than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. If the original *notice* of its decision is not in writing, the *IRO* must provide written confirmation of the decision to both the *claimant* and the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection.

### M. Designation of Authorized Representative

A *plan participant* is permitted to appoint an *authorized representative* to act on his/her behalf with respect to a benefit *claim* or *appeal* of a denial. In connection with a *claim* involving urgent care, the *Plan* will permit a health care professional with knowledge of the *plan participant's* medical condition to act as the *plan participant's authorized representative*. In the event a *plan participant* designates an *authorized representative*, all future communications from the *Plan* will be with the representative, rather than the *plan participant*, unless the *plan participant* directs the *Plan Administrator*, in writing, to the contrary. If you wish to change/alter your authorized representative, or the time frame, you will need to submit these changes in writing.

### N. Physical Examinations

The *Plan* reserves the right to have a *physician* of its own choosing examine any *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. All such examinations shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan* may reasonably require during the pendency of a *claim*. The *plan participant* must comply with this requirement as a necessary condition to coverage.

### O. Autopsy

The *Plan* reserves the right to have an autopsy performed upon any deceased *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. This right may be exercised only where not prohibited by law.

### P. Payment of Benefits

All benefits under this *Plan* are payable, in U.S. dollars, to the *plan participant* whose *illness* or *injury*, or whose covered *dependent's illness* or *injury*, is the basis of a *claim*. In the event of the death or incapacity of a *plan participant*, and in the absence of written evidence to this *Plan* of the qualification of a guardian for his/her estate, this *Plan* may, in its sole discretion, make any and all such payments to the individual or *institution* which, in the opinion of this *Plan*, is or was providing the care and support of such *employee*.

### Q. Assignment of Benefits

For provisions regarding assignment of benefits, refer to the *Plan's* wrap document.

### R. Non-U.S. Providers

Refer to the BlueCard Worldwide Program subsection, located in the **Medical Network Information** section, for details on coverage of non-U.S. providers.

### S. Recovery of Payments

Occasionally, benefits are paid more than once; are paid based upon improper billing or a misstatement in a proof of loss or enrollment information; are not paid according to the *Plan's* terms, conditions, limitations, or exclusions; or should otherwise not have been paid by the *Plan*. As such this *Plan* may pay benefits that are later found to be greater than the *maximum allowable charge*. In this case, this *Plan* may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such,

whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the *plan participant* or *dependent* on whose behalf such payment was made.

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

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

Providers and any other person or entity accepting payment from the *Plan* or to whom a right to benefits has been assigned, in consideration of services rendered, payments, and/or rights, agrees to be bound by the terms of this *Plan* and agree to submit *claims* for reimbursement in strict accordance with their state's health care practice acts, ICD-10 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator* or insurer. Any payments made on *claims* for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within thirty (30) days of discovery or demand or *incur* prejudgment interest of 1.5% per month. If the *Plan* must bring an action against a *plan participant*, provider, or other person or entity to enforce the provisions of this section, then that *plan participant*, provider, or other person or entity agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

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

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

1. in error
2. pursuant to a misstatement contained in a proof of loss or a fraudulent act
3. pursuant to a misstatement made to obtain coverage under this *Plan* within two (2) years after the date such coverage commences
4. with respect to an ineligible person
5. in anticipation of obtaining a recovery if a *plan participant* fails to comply with the *Plan's* **Reimbursement And Recovery Provisions**
6. pursuant to a *claim* for which benefits are recoverable under any policy or act of law providing for coverage for occupational *injury* or *disease* to the extent that such benefits are recovered

   This provision (6) shall not be deemed to require the *Plan* to pay benefits under this *Plan* in any such instance.

The deduction may be made against any *claim* for benefits under this *Plan* by a *plan participant* or by any of his/her covered *dependents* if such payment is made with respect to the *plan participant* or any person covered or asserting coverage as a *dependent* of the *plan participant*.

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

# SECTION XIII—COORDINATION OF BENEFITS

## A. Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of *covered charges* when two (2) or more plans, including *Medicare*, are paying. When a *plan participant* is covered by this *Plan* and another plan, or the *plan participant's* spouse is covered by this *Plan* and by another plan, or the couples covered children are covered under two (2) or more plans, the plans will coordinate benefits when a *claim* is received.

**Standard Coordination of Benefits (COB)**

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

**Example:** Assume all *deductibles* are met, billed services are considered *covered charges* under both plans, the primary plan pays 80% of the *allowable amount*, and the secondary plan pays 90% of the *allowable amount*. A *plan participant* incurs a *claim* with a *network* provider in which the *allowable amount* is $1,000.

| | |
|---|---|
| Primary Plan | $800 |
| Secondary Plan | $200 |
| Patient Responsibility | $0 |
| Total Amount Paid | $1,000 |

## B. Excess Insurance

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

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

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

## C. Allowable Charge

For a charge to be allowable it must be within the *Plan's maximum amount* and at least part of it must be covered under this *Plan*.

In the case of HMO (health maintenance organization) or other *network* only plans, this *Plan* will not consider any charges in excess of what an HMO or *network* provider has agreed to accept as payment in full. Also, when an HMO or *network* plan is primary and the *plan participant* does not use an HMO or *network* provider, this *Plan* will not consider as an *allowable charge* any charge that would have been covered by the HMO or *network* plan had the *plan participant* used the services of an HMO or *network* provider.

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

## D. General Limitations

When medical payments are available under any other insurance source, the *Plan* shall always be considered the secondary carrier.

## E. Application to Benefit Determinations

The plan that pays first according to the rules in the subsection entitled Benefit Plan Payment Order will pay as if there were no *other plan* involved. The secondary and subsequent plans will pay the balance due up to 100% of the total *allowable charges*. When there is a conflict in the rules, this *Plan* will never pay more than 50% of *allowable charges* when paying secondary. Benefits will be coordinated as referenced in the Claims Determination Period subsection.

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

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

1. the *other plan* would, according to its rules, determine its benefits after the benefits of this *Plan* have been determined
2. the rules in the subsection entitled Benefit Plan Payment Order would require this *Plan* to determine its benefits before the *other plan*

## F. Benefit Plan Payment Order

When two (2) or more plans provide benefits for the same *allowable charge*, benefit payment will adhere to these rules in the following order:

1. Plans that do not have a coordination provision, or one like this, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the *allowable charge*:
    a. The benefits of the plan which covers the person directly (that is, as an *employee*, member, or subscriber) are determined before those of the plan which covers the person as a *dependent*.
    b. The benefits of a benefit plan which covers a person as an *employee* who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired *employee*. The benefits of a benefit plan which covers a person as a *dependent* of an *employee* who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a *dependent* of a laid off or retired *employee*. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
    c. The benefits of a benefit plan which covers a person as an *employee* who is neither laid off nor retired or a *dependent* of an *employee* who is neither laid off nor retired are determined before those of a plan which covers the person as a *COBRA* beneficiary.
    d. When a child is covered as a *dependent* and the parents are not separated or divorced, these rules will apply:
        i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year.
        ii. If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
    e. When a *child's* parents are divorced or legally separated, these rules will apply:
        i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
        ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the step-parent that covers the *child* as a *dependent* will be considered next. The benefit plan of the parent without custody will be considered last.
        iii. This rule will be in place of items (i.) and (ii.) immediately above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the

child. In this case, the benefit plan of that parent will be considered before *other plans* that cover the child as a *dependent*.

iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of *benefit determination* rules outlined above when a child is covered as a *dependent* and the parents are not separated or divorced.

v. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

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

g. When a married *dependent* child is covered as a *dependent* on both a spouse's plan and a parent's plan, and the policies are both effective on the same day, the benefits of the policy holder whose birthday falls earlier in a year are determined before those of the policy holder whose birthday falls later in that year.

3. *Medicare* will pay primary, secondary, or last to the extent stated in federal law. Refer to the *Medicare* publication Your Guide to Who Pays First at **https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance/which-insurance-pays-first**. When *Medicare* would be the primary payer if the person had enrolled in *Medicare*, this *Plan* will base its payment upon benefits that would have been paid by *Medicare* under Parts A and B, regardless of whether or not the person was enrolled under any of these parts. The *Plan* reserves the right to coordinate benefits with respect to *Medicare* Part D. The *Plan Administrator* will make this determination based on the information available through Centers for Medicare & Medicaid Services (CMS). If CMS does not provide sufficient information to determine the amount *Medicare* would pay, the *Plan Administrator* will make *reasonable* assumptions based on published *Medicare* fee schedules.

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

5. When an adult *dependent* is covered by his/her spouse's plan and is also covered by his/her parent's plan, the benefits of the benefit plan which has covered the patient for the longest time are determined before those of the *other plan*.

6. When an adult *dependent* is covered by multiple parents' plans, the benefits of the benefit plan of the parent whose birthday falls earlier in the year are determined before those of the benefit plan of the parent whose birthday falls later in that year. Should both/all parents have the same birthday, the benefits of the benefit plan which has covered the patient the longest shall be determined first.

7. The *Plan* will pay primary to Tricare and a state *Children's Health Insurance Plan* to the extent required by federal law.

## G. Coordination with Government Programs

1. **Medicaid/IHS.** If a *plan participant* is covered by both this *Plan* and Medicaid or Indian Health Services (IHS), this *Plan* pays first and Medicaid or IHS pays second.

2. **Veterans Affairs or Military Medical Facility Services.** If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military service-related *illness* or *injury*, benefits are not covered by this *Plan*. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military service-related *illness* or *injury*, benefits are covered by the *Plan* to the extent those services are *medically necessary* and the charges are within this *Plan's maximum allowable charge*.

3. **Other Coverage Provided by State or Federal Law.** If you are covered by both this *Plan* and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this *Plan* pays second, unless applicable law dictates otherwise.

### H. Claims Determination Period

Benefits will be coordinated on a *calendar year* basis. This is called the claims determination period.

### I. Right to Receive or Release Necessary Information

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

### J. Facility of Payment

Whenever payments which should have been made under this *Plan* in accordance with this provision have been made under any *other plans*, the *Plan Administrator* may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this *Plan* and, to the extent of such payments, this *Plan* shall be fully discharged from liability. This *Plan* may repay *other plans* for benefits paid that the *Plan Administrator* determines it should have paid. That repayment will count as a valid payment under this *Plan*.

### K. Right of Recovery

In accordance with the **Claims and Appeals** section, Recovery of Payments subsection, whenever payments have been made by this *Plan* with respect to *allowable charges* in a total amount, at any time, in excess of the *maximum amount* of payment necessary at that time to satisfy the intent of this article, the *Plan* shall have the right to recover such payments, to the extent of such excess, from any one (1) or more of the following as this *Plan* shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the *Plan* determines are responsible for payment of such *allowable charges*, and any future benefits payable to the *plan participant* or his/her *dependents*. Please see the Recovery of Payments subsection for more details.

### L. Exception to Medicaid

In accordance with *ERISA*, the *Plan* shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the *Plan* or making a determination about the payments for benefits received by a *plan participant* under the *Plan*.

# SECTION XIV—MEDICARE

### A. Application to Active Employees and Their Spouses

An *active employee* and his/her spouse (when eligible for *Medicare*) may, at the option of such *employee*, elect or reject coverage under this *Plan*. If such *employee* elects coverage under this *Plan*, the benefits of this *Plan* shall be determined before any benefits provided by *Medicare*. If coverage under this *Plan* is rejected by such *employee*, benefits listed herein will not be payable even as secondary coverage to *Medicare*.

### B. Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by federal regulations, this *Plan* will pay before any *Medicare* benefits. There are some circumstances under which *Medicare* would be required to pay its benefits first. In these cases, benefits under this *Plan* would be calculated as the secondary payer (as described under the section entitled **Coordination of Benefits**). The *plan participant* will be assumed to have full *Medicare* coverage (that is, both Parts A & B) whether or not the *plan participant* has enrolled for the full coverage. If the provider accepts assignment with *Medicare*, *covered charges* will not exceed the *Medicare* approved expenses.

# SECTION XV—REIMBURSEMENT AND RECOVERY PROVISIONS

## A. Payment Condition

The *Plan*, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an *injury*, *illness*, *disease*, or disability is caused in whole or in part by, or results from the acts or omissions of *plan participants*, and/or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns [collectively referred to hereinafter in this section as *plan participant(s)*] or a third party, where any party besides the *Plan* may be responsible for expenses arising from said incident, and/or other funds are available. This includes but is not limited to: *no-fault auto insurance* coverage, uninsured or underinsured motorist, medical payment provisions, third-party assets, third-party insurance, and/or guarantor(s) of a third party (collectively referred to as coverage).

*Plan participant(s)*, his/her attorney, and/or *legal guardian* of a minor or incapacitated individual agrees that acceptance of the *Plan's* conditional payment of medical benefits is constructive *notice* of these provisions in their entirety and agrees to maintain 100% of the *Plan's* conditional payment of benefits or the full extent of payment from any one (1) or combination of first and third-party sources in trust, without disruption except for reimbursement to the *Plan* or the *Plan's* assignee. By accepting benefits, the *plan participant(s)* agrees the *Plan* shall have an equitable lien on any funds received by the *plan participant(s)* and/or their attorney from any source, and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The *plan participant(s)* agrees to include the *Plan's* name as a co-payee on any and all settlement drafts. Further, by accepting benefits the *plan participant(s)* understands that any recovery obtained pursuant to this section is an asset of the *Plan* to the extent of the amount of benefits paid by the *Plan* and that the *plan participant* shall be a trustee over those *Plan* assets.

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

If there is more than one (1) party responsible for charges paid by the *Plan*, or may be responsible for charges paid by the *Plan*, the *Plan* will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple *injured* parties of which the *plan participant(s)* is/are only one (1) or a few, that unallocated settlement fund is considered designated as an identifiable fund from which the *Plan* may seek reimbursement.

## B. Subrogation

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

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

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

If the *plan participant(s)* fails to file a *claim* or pursue damages against:

1. any primary payer besides the *Plan*
2. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured or underinsured motorist coverage

3. any policy of insurance from any insurance company or guarantor of a third party
4. workers' compensation or other liability insurance company
5. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payments

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

### C. Right of Reimbursement

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

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

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

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

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

### D. Participant is a Trustee Over Plan Assets

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

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

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

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

### E. Release of Liability

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

### F. Excess Insurance

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

The *Plan's* benefits shall be excess to any of the following:

1. the responsible party, its insurer, or any other source on behalf of that party
2. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured or underinsured motorist coverage
3. any policy of insurance from any insurance company or guarantor of a third party
4. workers' compensation or other liability insurance company
5. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payment

### G. Separation of Funds

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

### H. Wrongful Death

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

### I. Obligations

It is the *plan participant's* obligation at all times, both prior to and after payment of medical benefits by the *Plan*:

1. to cooperate with the *Plan*, or any representatives of the *Plan*, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the *Plan's* rights

2. to provide the *Plan* with pertinent information regarding the *illness*, *disease*, disability, or *injury*, including *accident* reports, settlement information, and any other requested additional information
3. to take such action and execute such documents as the *Plan* may require to facilitate enforcement of its subrogation and reimbursement rights
4. to do nothing to prejudice the *Plan's* rights of subrogation and reimbursement
5. to promptly reimburse the *Plan* when a recovery through settlement, judgment, award, or other payment is received
6. to *notify* the *Plan* or its *authorized representative* of any settlement prior to finalization of the settlement
7. to *notify* the *Plan* or its *authorized representative* of any incident-related claims or care which may not be identified within the lien (but has been *incurred*) and/or reimbursement request submitted by or on behalf of the *Plan*
8. to not settle or release, without the prior consent of the *Plan*, any *claim* to the extent that the *plan participant* may have against any responsible party or coverage
9. to instruct his or her attorney to ensure that the *Plan* and/or its authorized representative is included as a payee on any settlement draft
10. in circumstances where the *plan participant* is not represented by an attorney, instruct the insurance company or any third party from whom the *plan participant* obtains a settlement to include the *Plan* or its *authorized representative* as a payee on the settlement draft
11. to make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the *Plan* and *plan participant* over settlement funds is resolved

If the *plan participant(s)* and/or his/her attorney fails to reimburse the *Plan* for all benefits paid or to be paid, *incurred*, or that will be *incurred* prior to the date of the release of liability from the relevant entity, as a result of said *injury* or condition, out of any proceeds, judgment, or settlement received, the *plan participant(s)* will be responsible for any and all expenses (whether fees or costs) associated with the *Plan's* attempt to recover such money from the *plan participant(s)*.

The *Plan's* rights to reimbursement and/or subrogation are in no way dependent upon the *plan participant's* cooperation or adherence to these terms.

### J. Offset

Failure by the *plan participant(s)* and/or his/her attorney to comply with any of these requirements may, at the *Plan's* discretion, result in a forfeiture of payment by the *Plan* of medical benefits, and any funds or payments due under this *Plan* on behalf of the *plan participant(s)* may be withheld until the *plan participant(s)* satisfies his/her obligation. This provision applies even if the *plan participant(s)* has disbursed settlement funds.

### K. Minor Status

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

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

### L. Language Interpretation

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

# SECTION XVI—CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the *Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)*, certain *employees* and their families covered under the Worthington Industries Group Welfare Plan (*Plan*) will be entitled to the opportunity to elect a temporary extension of health coverage (called *COBRA* continuation coverage) where coverage under the *Plan* would otherwise end. This *notice* is intended to inform *plan participants* and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of *COBRA*, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This *notice* is intended to reflect the law and does not grant or take away any rights under the law.

Refer to the Quick Reference Information Chart for the COBRA Administrator's contact information. Complete instructions on *COBRA*, as well as election forms and other information, will be provided by the *Plan Administrator* or its designee to *plan participants* who become qualified beneficiaries under *COBRA*.

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a thirty (30)-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept *late enrollees*.

### A. COBRA Continuation Coverage

*COBRA* continuation coverage is the temporary extension of group health plan coverage that must be offered to certain *plan participants* and their eligible family members (called qualified beneficiaries) at group rates. The right to *COBRA* continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the *Plan* (the qualifying event). The coverage must be identical to the *Plan* coverage that the qualified beneficiary had immediately before the qualifying event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated *active employees* who have not experienced a qualifying event (in other words, similarly situated non-*COBRA* beneficiaries).

*COBRA* continuation coverage does not run concurrent with the coverage under the terms of the *Plan*.

### B. Qualified Beneficiary

In general, a qualified beneficiary can be:

1. Any individual who, on the day before a qualifying event, is covered under a *Plan* by virtue of being on that day either a covered *employee*, the spouse of a covered *employee*, or a *dependent* child of a covered *employee*. If, however, an individual who otherwise qualifies as a qualified beneficiary is denied or not offered coverage under the *Plan* under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the *Plan* coverage and will be considered a qualified beneficiary if that individual experiences a qualifying event.
2. Any child who is born to or placed for adoption or foster care with a covered *employee* during a period of *COBRA* continuation coverage, and any individual who is covered by the *Plan* as an *alternate recipient* under a *Qualified Medical Child Support Order*. If, however, an individual who otherwise qualifies as a qualified beneficiary is denied or not offered coverage under the *Plan* under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the *Plan* coverage and will be considered a qualified beneficiary if that individual experiences a qualifying event.
3. A covered *employee* who retired on or before the date of substantial elimination of *Plan* coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the *employer*, as is the spouse, surviving spouse, or *dependent* child of such a covered *employee* if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or *dependent* child was a beneficiary under the *Plan*.

The term 'covered *employee*' includes any individual who is provided coverage under the *Plan* due to his/her performance of services for the *employer* sponsoring the *Plan*, self-employed individuals, independent contractor, or corporate director. However, this provision does not establish eligibility of these individuals. Eligibility for *Plan* coverage shall be determined in accordance with *Plan's* wrap document.

An individual is not a qualified beneficiary if the individual's status as a covered *employee* is attributable to a period in which the individual was a nonresident alien who received from the individual's *employer* no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a

qualified beneficiary, then a spouse or *dependent* child of the individual will also not be considered a qualified beneficiary by virtue of the relationship to the individual.

A domestic partner and his or her children are not qualified beneficiaries and do not have an independent right to elect *COBRA* continuation coverage. However, if an *employee* who is a qualified beneficiary elects *COBRA* continuation coverage for himself or herself, he or she may also elect to continue coverage for his or her domestic partner if they are covered under the *Plan* on the day before the qualifying event.

Each qualified beneficiary (including a child who is born to or placed for adoption or foster care with a covered *employee* during a period of *COBRA* continuation coverage) must be offered the opportunity to make an independent election to receive *COBRA* continuation coverage.

### C. Qualifying Event

The following are considered to be qualifying events if they would cause the *plan participant* to lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of *COBRA* continuation coverage:

1. the death of a covered *employee*
2. the termination (other than by reason of the *employee's* gross misconduct), or reduction of hours, of a covered *employee's* employment
3. the divorce or legal separation of a covered *employee* from the *employee's* spouse

   If the *employee* reduces or eliminates the *employee's* spouse's *Plan* coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.
4. a covered *employee's* enrollment in any part of the *Medicare* program
5. a *dependent* child's ceasing to satisfy the *Plan's* requirements for a *dependent* child (for example, attainment of the maximum age for dependency under the *Plan*)

If the qualifying event causes the covered *employee*, or the covered spouse or a *dependent* child of the covered *employee*, to cease to be covered under the *Plan* under the same terms and conditions as in effect immediately before the qualifying event [or in the case of the bankruptcy of the *employer*, any substantial elimination of coverage under the *Plan* occurring within twelve (12) months before or after the date the bankruptcy proceeding commences], the persons losing such coverage become qualified beneficiaries under *COBRA* if all the other conditions of the *COBRA* are also met. For example, any increase in contribution that must be paid by a covered *employee*, the spouse, or a *dependent* child of the covered *employee*, for coverage under the *Plan* that results from the occurrence of one (1) of the events listed above is a loss of coverage.

The taking of leave under the *Family and Medical Leave Act of 1993 (FMLA)* does not constitute a qualifying event. A qualifying event will occur, however, if an *employee* does not return to employment at the end of the *FMLA leave* and all other *COBRA* continuation coverage conditions are present. If a qualifying event occurs, it occurs on the last day of *FMLA leave*, and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the *Plan* provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered *employee* and family members will be entitled to *COBRA* continuation coverage even if they failed to pay the *employee* portion of premiums for coverage under the *Plan* during the *FMLA leave*.

**Dependents of Deceased Employees**

Spouses and *dependent* children of deceased *employees* are eligible for COBRA continuation coverage at the *employee* rate for two (2) years. Remaining time of COBRA coverage will be available at full cost.

### D. Notice of Unavailability of Continuation Coverage

The *Plan* may sometimes deny a request for *COBRA* coverage, including an extension of coverage, when the *Plan Administrator* determines the *plan participant* is not entitled to receive it.

When a *Plan Administrator* makes the decision to deny a request for *COBRA* coverage from a *plan participant*, the *Plan* must give the *plan participant* a *notice* of unavailability of *COBRA* coverage. The *notice* must be provided within fourteen (14) days after the request is received relating to a qualifying event, second qualifying event, or

determination of disability by the Social Security Administration, and the *notice* must explain the reason for denying the request.

### E. Factors to Consider in Electing COBRA Continuation Coverage

When considering options for health coverage, qualified beneficiaries should consider:

1. **Premiums.** This *Plan* can charge up to 102% of total plan premiums for *COBRA* coverage. Other options, like coverage on a spouse's plan or through the marketplace, may be less expensive. Qualified beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's *employer*) within thirty (30) days after *Plan* coverage ends due to one (1) of the qualifying events listed above.
2. **Provider Networks.** If a qualified beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a *network* in considering options for health coverage.
3. **Drug Formularies.** For qualified beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.
4. **Severance Payments.** If *COBRA* rights arise because the *employee* has lost his job and there is a severance package available from the *employer*, the former *employer* may have offered to pay some or all of the *employee's COBRA* payments for a period of time. This can affect the timing of coverage available in the marketplace. In this scenario, the *employee* may want to contact the Department of Labor at 1.866.444.3272 to discuss options.
5. **Service Areas.** If benefits under the *Plan* are limited to specific service or coverage areas, benefits may not be available to a qualified beneficiary who moves out of the area.
6. **Other Cost-Sharing.** In addition to premiums or contributions for health coverage, the *Plan* requires *participants* to pay *co-payments*, *deductibles*, *co-insurance*, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher *deductible* and higher *co-payments*.

**Other Coverage Options**

Instead of enrolling in *COBRA* continuation coverage, there may be other coverage options for qualified beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a special enrollment period. Some of these options may cost less than *COBRA* continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

### F. Procedure for Obtaining COBRA Continuation Coverage

The *Plan* has conditioned the availability of *COBRA* continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

### G. The Election Period

The election period is the timeframe within which the qualified beneficiary must elect *COBRA* continuation coverage under the *Plan*. The election period must begin no later than the date the qualified beneficiary would lose coverage on account of the qualifying event and ends sixty (60) days after the later of the date the qualified beneficiary would lose coverage on account of the qualifying event or the date *notice* is provided to the qualified beneficiary of his/her right to elect *COBRA* continuation coverage. If coverage is not elected within the sixty (60) day period, all rights to elect *COBRA* continuation coverage are forfeited.

**Note:** If a covered *employee* who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the *employee* and his or her covered *dependents* have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of sixty (60) days or less and only during the six (6) months immediately after their group health plan coverage ended. Any person who

qualifies or thinks that they and/or their family members may qualify for assistance under this special provision should contact the *Plan Administrator* for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period. Refer to the Quick Reference Information Chart for the *Plan Administrator's* contact information.

### H. Responsibility for Informing the Plan Administrator of the Occurrence of a Qualifying Event

The *Plan* will offer *COBRA* continuation coverage to qualified beneficiaries only after the *Plan Administrator* or its designee has been timely notified that a *qualifying event* has occurred. The *employer* (if the *employer* is not the *Plan Administrator*) will *notify* the *Plan Administrator* of the *qualifying event* within thirty (30) days following the date coverage ends when the qualifying event is any of the following:

1. the end of employment or reduction of hours of employment
2. death of the *employee*
3. commencement of a proceeding in bankruptcy with respect to the *employer*
4. enrollment of the *employee* in any part of *Medicare*

**IMPORTANT:**

For the other qualifying events (divorce or legal separation of the *employee* and spouse or a *dependent* child's losing eligibility for coverage as a *dependent* child), you or someone on your behalf must *notify* the *Plan Administrator* or its designee in writing within sixty (60) days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed, or if the *notice* is not provided in writing to the *Plan Administrator* or its designee during the sixty (60) day *notice* period, any spouse or *dependent* child who loses coverage will not be offered the option to elect continuation coverage. You must send this *notice* to the *Plan Sponsor*.

**Notice Procedures**

Any *notice* that you provide must be **in writing**. Oral *notice*, including *notice* by telephone, is not acceptable. You must mail, fax, or hand-deliver your *notice* to the person, department, or firm listed below, at the following address:

NueSynergy
4601 College Blvd
Suite 280
Leawood, KS 66211

Phone: 1.855.890.7239

If mailed, your *notice* must be postmarked no later than the last day of the required *notice* period. Any *notice* you provide must state all of the following:

1. the name of the plan or plans under which you lost or are losing coverage
2. the name and address of the *employee* covered under the *Plan*
3. the name(s) and address(es) of the qualified beneficiary(ies)
4. the qualifying event and the date it happened

If the qualifying event is a **divorce or legal separation**, your *notice* must include a **copy of the divorce decree or the legal separation agreement.**

Be aware that there are other *notice* requirements in other contexts, for example, in order to qualify for a disability extension.

Once the *Plan Administrator* or its designee receives timely *notice* that a qualifying event has occurred, *COBRA* continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect *COBRA* continuation coverage. Covered *employees* may elect *COBRA* continuation coverage for their spouses, and parents may elect *COBRA* continuation coverage on behalf of their children. For each qualified beneficiary who elects *COBRA* continuation coverage, *COBRA* continuation coverage will begin on the date that *Plan* coverage would otherwise have been lost. If you or your spouse or *dependent* children do not elect continuation coverage within the sixty (60) day election period described above, the right to elect continuation coverage will be lost.

### I. Waiver Before the End of the Election Period

If, during the election period, a qualified beneficiary waives *COBRA* continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of *COBRA* continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the *Plan Administrator* or its designee, as applicable.

### J. If a Qualified Beneficiary Has Other Group Health Plan Coverage or Medicare

Qualified beneficiaries who are entitled to elect *COBRA* continuation coverage may do so even if they are covered under another group health plan or are entitled to *Medicare* benefits on or before the date on which *COBRA* is elected. However, a qualified beneficiary's *COBRA* coverage will terminate automatically if, after electing *COBRA*, he or she becomes entitled to *Medicare* or becomes covered under other group health plan coverage.

### K. When a Qualified Beneficiary's COBRA Continuation Coverage Can be Terminated

During the election period, a qualified beneficiary may waive *COBRA* continuation coverage. Except for an interruption of coverage in connection with a waiver, *COBRA* continuation coverage that has been elected for a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates:

1. the last day of the applicable maximum coverage period
2. the first day for which *timely payment* is not made to the *Plan* with respect to the qualified beneficiary
3. the date upon which the *employer* ceases to provide any group health plan (including a successor plan) to any *employee*
4. the date, after the date of the election, that the qualified beneficiary first becomes covered under any *other plan*
5. the date, after the date of the election that the qualified beneficiary first enrolls in the *Medicare* program (either Part A or Part B, whichever occurs earlier)
6. in the case of a qualified beneficiary entitled to a disability extension, the later of:
    a. twenty-nine (29) months after the date of the qualifying event
    b. the first day of the month that is more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier
    c. the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension

The *Plan* can terminate for cause the coverage of a qualified beneficiary on the same basis that the *Plan* terminates for cause the coverage of similarly situated non-*COBRA* beneficiaries, for example, for the submission of a fraudulent *claim*.

In the case of an individual who is not a qualified beneficiary and who is receiving coverage under the *Plan* solely because of the individual's relationship to a qualified beneficiary, if the *Plan's* obligation to make *COBRA* continuation coverage available to the qualified beneficiary ceases, the *Plan* is not obligated to make coverage available to the individual who is not a qualified beneficiary.

When the *Plan* terminates *COBRA* coverage early for any of the reasons listed above, the *Plan Administrator* must give the qualified beneficiary a *notice* of early termination. The *notice* must be given as soon as practicable after the decision is made, and it must describe all of the following:

1. the date of termination of *COBRA* coverage
2. the reason for termination
3. any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage, such as a right to convert to an individual policy

**L. Maximum Coverage Periods for COBRA Continuation Coverage**

The maximum coverage periods are based on the type of the qualifying event and the status of the qualified beneficiary, as shown below.

1. In the case of a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends either:
    a. eighteen (18) months after the qualifying event if there is not a disability extension
    b. twenty-nine (29) months after the qualifying event if there is a disability extension
2. In the case of a covered *employee's* enrollment in the *Medicare* program before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period for qualified beneficiaries other than the covered *employee* ends on the later of:
    a. thirty-six (36) months after the date the covered *employee* becomes enrolled in the *Medicare* program
    b. eighteen (18) months [or twenty-nine (29) months, if there is a disability extension] after the date of the covered *employee's* termination of employment or reduction of hours of employment
3. In the case of a qualified beneficiary who is a child born to or placed for adoption or foster care with a covered *employee* during a period of *COBRA* continuation coverage, the maximum coverage period is the maximum coverage period applicable to the qualifying event giving rise to the period of *COBRA* continuation coverage during which the child was born or placed for adoption or foster care.
4. In the case of any other qualifying event than that described above, the maximum coverage period ends thirty-six (36) months after the qualifying event.

**M. Circumstances in Which the Maximum Coverage Period Can Be Expanded**

If a qualifying event that gives rise to an eighteen (18) month or twenty-nine (29) month maximum coverage period is followed, within that eighteen (18) or twenty-nine (29) month period, by a second qualifying event that gives rise to a thirty-six (36) months maximum coverage period, the original period is expanded to thirty-six (36) months, but only for individuals who are qualified beneficiaries at the time of and with respect to both qualifying events. In no circumstance can the *COBRA* maximum coverage period be expanded to more than thirty-six (36) months after the date of the first qualifying event. The *Plan Administrator* must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This *notice* must be sent to the *Plan Sponsor* in accordance with the procedures above.

**N. How a Qualified Beneficiary Becomes Entitled to a Disability Extension**

A disability extension will be granted if an individual (whether or not the covered *employee*) who is a qualified beneficiary in connection with the *qualifying event* that is a termination or reduction of hours of a covered *employee's* employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first sixty (60) days of *COBRA* continuation coverage. To qualify for the disability extension, the qualified beneficiary must also provide the *Plan Administrator* with *notice* of the disability determination on a date that is both within sixty (60) days after the date of the determination and before the end of the original eighteen (18) month maximum coverage. Said *notice* shall be provided to the *Plan Administrator*, in writing, and should be sent to the *Plan Sponsor* in accordance with the procedures above.

**O. Payment for COBRA Continuation Coverage**

For any period of *COBRA* continuation coverage under the *Plan*, qualified beneficiaries who elect *COBRA* continuation coverage must pay for *COBRA* continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of *COBRA* continuation coverage covering a disabled qualified beneficiary due to a disability extension. The *Plan* will terminate a qualified beneficiary's *COBRA* continuation coverage as of the first day of any period for which *timely payment* is not made.

The *Plan* must allow payment for COBRA continuation coverage to be made in monthly installments. The *Plan* is also permitted to allow for payment at other intervals.

### P. Timely Payment for COBRA Continuation Coverage

*Timely payment* means a payment made no later than thirty (30) days after the first day of the coverage period. Payment that is made to the *Plan* by a later date is also considered *timely payment* if either under the terms of the *Plan*, covered *employees* or qualified beneficiaries are allowed until that later date to pay for their coverage for the period, or under the terms of an arrangement between the *employer* and the entity that provides *Plan* benefits on the *employer's* behalf, the *employer* is allowed until that later date to pay for coverage of similarly situated non-*COBRA* beneficiaries for the period.

Notwithstanding the above paragraph, the *Plan* does not require payment for any period of *COBRA* continuation coverage for a qualified beneficiary earlier than forty-five (45) days after the date on which the election of *COBRA* continuation coverage is made for that qualified beneficiary. Payment is considered made on the date on which it is postmarked to the *Plan*.

If *timely payment* is made to the *Plan* in an amount that is not significantly less than the amount the *Plan* requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the *Plan's* requirement for the amount to be paid, unless the *Plan* notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A reasonable period of time is thirty (30) days after the *notice* is provided. A shortfall in a *timely payment* is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

### Q. Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage

If a qualified beneficiary's *COBRA* continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the *Plan* will, during the one hundred eighty (180) day period that ends on that expiration date, provide the qualified beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-*COBRA* beneficiaries under the *Plan*.

### R. If You Have Questions

If you have questions about your *COBRA* continuation coverage, you should contact the *Plan Sponsor*. For more information about your rights under *ERISA*, including *COBRA*, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at **www.dol.gov/ebsa**.

### S. Keep Your Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the *Plan Administrator* informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any *notices* you send to the *Plan Administrator*.

### T. If You Wish to Appeal

In general, *COBRA*-related *claims* are not governed by *ERISA* and the related federal regulations. In an effort to provide all qualified beneficiaries with a fair and thorough review process for *COBRA* related *claims*, all determinations regarding *COBRA* eligibility and coverage will be made in accordance with the **Continuation Coverage Rights Under COBRA** section of this governing summary plan description. Accordingly, if a qualified beneficiary wishes to *appeal* a *COBRA* eligibility or coverage determination made by the *Plan*, such *claims* must be submitted consistent with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. The *Plan* will respond to all complete *appeals* in accordance with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. A qualified beneficiary who files an *appeal* with the *Plan* must exhaust the administrative remedies afforded by the *Plan* prior to pursuing civil action in federal court under *COBRA*.

# SECTION XVII—FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the *Plan* is funded as follows:

### A. For Employee and Dependent Coverage

The *employer* shares the cost of *employee* and *dependent* coverage under this *Plan* with the covered *employees*. Funding is derived from the funds of the *employer* and contributions made by the covered *employees*.

The level of any *employee* contributions will be set by the *Plan Administrator*. These *employee* contributions will be used in funding the cost of the *Plan* as soon as practicable after they have been received from the *employee* or withheld from the *employee's* pay through payroll deduction. The *Plan Administrator* reserves the right to change the level of *employee* contributions.

Benefits are paid directly from the *Plan* through the *Claims Administrator*.

### B. Plan is not an Employment Contract

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

### C. Clerical Error

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

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

# SECTION XVIII—CERTAIN PLAN PARTICIPANTS' RIGHTS UNDER ERISA

*Plan participants* in this *Plan* are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*. *ERISA* specifies that all *plan participants* shall be entitled to:

1. examine, without charge, at the *Plan Administrator's* office, all plan documents and copies of all documents governing the *Plan*, including 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
2. obtain copies of all plan documents and other *Plan* information upon written request to the *Plan Administrator*

   The *Plan Administrator* may make a *reasonable* charge for the copies.
3. continue health care coverage for a *plan participant*, spouse, or other *dependents* if there is a loss of coverage under the *Plan* as a result of a qualifying event

   *Employees* or *dependents* may have to pay for such coverage.
4. review this summary plan description and the documents governing the *Plan* or the rules governing *COBRA* continuation coverage rights

### A. Enforce Your Rights

If a *plan participant's claim* for a benefit is denied or ignored, in whole or in part, the *plan participant* has 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 a *plan participant* can take to enforce the above rights. For instance, if a *plan participant* requests a copy of plan documents or the latest annual report from the *Plan* and does not receive them within thirty (30) days, he or she may file suit in a federal court. In such a case, the court may require the *Plan Administrator* to provide the materials and to pay the *plan participant* up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the *Plan Administrator*. If the *plan participant* has a *claim* for benefits which is denied or ignored, in whole or in part, the *plan participant* may file suit in state or federal court.

In addition, if a *plan participant* disagrees with the *Plan's* decision or lack thereof concerning the qualified status of a *medical child support order*, he or she may file suit in federal court.

### B. Prudent Actions by Plan Fiduciaries

In addition to creating rights for *plan participants*, ERISA imposes obligations upon the individuals who are responsible for the operation of the *Plan*. The individuals who operate the *Plan*, called fiduciaries of the *Plan*, have a duty to do so prudently and in the interest of the *plan participants* and their beneficiaries. No one, including the *employer* or any other person, may fire a *plan participant* or otherwise discriminate against a *plan participant* in any way to prevent the *plan participant* from obtaining benefits under the *Plan* or from exercising his/her rights under ERISA.

If it should happen that the *Plan* fiduciaries misuse the *Plan's* money, or if a *plan participant* is discriminated against for asserting his/her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the *plan participant* is successful, the court may order the person sued to pay these costs and fees. If the *plan participant* loses, the court may order him/her to pay these costs and fees (for example, if it finds the *claim* or suit to be frivolous).

### C. Assistance with Your Questions

If the *plan participant* has any questions about the *Plan*, he or she should contact the *Plan Administrator* as outlined in the Quick Reference Information Chart. If the *plan participant* has any questions about this statement or his/her rights under ERISA, including *COBRA* or the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, that *plan participant* should contact either the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at **www.dol.gov/ebsa**. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

# SECTION XIX—FEDERAL NOTICES

## A. Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

An *employee* or *dependent* who is eligible, but not enrolled in this *Plan*, may enroll if:

1. The *employee* or *dependent* is covered under a Medicaid plan under Title XIX of the Social Security Act or a state children's health insurance program (CHIP) under Title XXI of such Act, and coverage of the *employee* or *dependent* is terminated due to loss of eligibility for such coverage, and the *employee* or *dependent* requests enrollment in this *Plan* within sixty (60) days after such Medicaid or CHIP coverage is terminated.
2. The *employee* or *dependent* becomes eligible for assistance with payment of *employee* contributions to this *Plan* through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the *employee* or *dependent* requests enrollment in this *Plan* within sixty (60) days after the date the *employee* or *dependent* is determined to be eligible for such assistance.

If a *dependent* becomes eligible to enroll under this provision and the *employee* is not then enrolled, the *employee* must enroll in order for the *dependent* to enroll.

## B. Genetic Information Nondiscrimination Act of 2008 (GINA)

*GINA* generally prohibits discrimination in group premiums based on *genetic information* and the use of *genetic information* as a basis for determining eligibility or setting premiums, and places limitations on genetic testing and the collection of *genetic information* in group health plan coverage. GINA provides clarification with respect to the treatment of *genetic information* under privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## C. Mental Health Parity and Addiction Equity Act of 2008

Regardless of any limitations on benefits for *mental disorders/substance use disorder* treatment otherwise specified in the *Plan*, any aggregate lifetime limit, annual limit, financial requirement, *non-network* exclusion, or treatment limitation on *mental disorders/substance use disorder* benefits imposed by the *Plan* shall comply with federal parity requirements, if applicable.

## D. Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not do any of the following:

1. restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section
2. set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) or ninety-six (96) hours, as applicable, stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay
3. require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) or ninety-six (96) hours, as applicable

However, the plan or issuer may pay for a shorter stay than forty-eight (48) hours following a vaginal delivery, or ninety-six (96) hours following a delivery by cesarean section if the attending provider (e.g., your *physician*, nurse midwife or *physician* assistant), discharges the mother or newborn after consultation with the mother.

## E. Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

*Employees* going into or returning from military service may elect to continue *Plan* coverage as mandated by the *Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)* under the following circumstances. These rights apply only to *employees* and their *dependents* covered under the *Plan* immediately before leaving for military service.

1. The maximum period of coverage of a person and the person's *dependents* under such an election shall be the lesser of:
    a. the twenty-four (24) month period beginning on the date on which the person's absence begins
    b. the day after the date on which the person was required to apply for or return to a position of employment and fails to do so
2. A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the *Plan*, except a person on active duty for twelve (12) months or less will not be required to pay more than the *employee's* share, if any, for the coverage.
3. An exclusion or *waiting period* may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or *waiting period* may be imposed for coverage of any *illness* or *injury* determined by the Secretary of Veterans Affairs to have been *incurred* in, or aggravated during, the performance of *uniformed service*.

If the *employee* wishes to elect this coverage or obtain more detailed information, contact the *Plan Administrator* as outlined in the Quick Reference Information Chart. The *employee* may also have continuation rights under *USERRA*. In general, the *employee* must meet the same requirements for electing *USERRA* coverage as are required under *COBRA* continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The *employee* may elect *USERRA* continuation coverage for the *employee* and their *dependents*. Only the *employee* has election rights. *Dependents* do not have any independent right to elect *USERRA* health plan continuation.

### F. Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires that you be informed of your rights to *surgery* and prostheses following a covered *mastectomy*.

The *Plan* will pay charges *incurred* for a *plan participant* who is receiving benefits in connection with a *mastectomy* and then elects breast reconstruction in connection with the *mastectomy*. Coverage will include:

1. reconstruction of the breast on which the *mastectomy* has been performed
2. *surgery* and reconstruction of the other breast to produce a symmetrical appearance
3. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

# SECTION XX—DEFINED TERMS

The following terms have special meanings and will be italicized when used in this *Plan*. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

**Accident**

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

**Accidental Injury (Accidental Injuries)**

An objectively demonstrable impairment of bodily function caused by trauma from a sudden, unforeseen outside force or object, occurring at an identifiable time and place, and without the *plan participant's* foresight or expectation.

**Active Employee**

For information regarding eligibility for *employees*, refer to the *Plan's* wrap document.

**Active Employment**

Performance by the *employee* of all the regular duties of his/her occupation at an established business location of the participating *employer*, or at another location to which he or she may be required to travel to perform the duties of his/her employment. An *employee* shall be deemed actively at work if the *employee* is absent from work due to a health factor. In no event will an *employee* be considered actively at work if he/she has effectively terminated employment.

**Adoptive Cell Therapy**

A type of immunotherapy in which T cells (a type of immune cell) are given to a patient to help the body fight diseases, such as cancer. In cancer therapy, T cells are usually taken from the patient's own blood or tumor tissue, grown in large numbers in the laboratory, and then given back to the patient to help the immune system fight the cancer. Sometimes, the T cells are changed in the laboratory to make them better able to target the patient's cancer cells and kill them. Types of adoptive cell therapy include, but not limited to, chimeric antigen receptor T-cell (CAR T-cell) therapy and tumor-infiltrating lymphocyte (TIL) therapy. Also called adoptive cell transfer, *cellular immunotherapy*, and T-cell transfer therapy.

**Adverse Benefit Determination**

Any of the following: a denial, reduction, rescission, or termination of a *claim* for benefits, or a failure to provide or make payment for such a *claim* (in whole or in part) including determinations of a *claimant's* eligibility, the application of any review under the Care Coordination Program, and determinations that an item or service is *experimental/investigational* or not *medically necessary* or appropriate.

**Allowable Charges**

The *maximum amount/maximum allowable charge* for any *medically necessary*, eligible item of expense, at least a portion of which is covered under a plan. When some *other plan* pays first in accordance with the Application to Benefit Determinations subsection in the **Coordination of Benefits** section herein, this *Plan's* allowable charges shall in no event exceed the *other plan's* allowable charges. When some *other plan* provides benefits in the form of services rather than cash payments, the *reasonable* cash value of each service rendered, in the amount that would be payable in accordance with the terms of the *Plan*, shall be deemed to be the benefit. Benefits payable under any *other plan* include the benefits that would have been payable had *claim* been duly made therefore.

**Alternate Recipient**

Any child of a *plan participant* who is recognized under a *medical child support order* as having a right to enrollment under this *Plan* as the *plan participant's* eligible *dependent*. For purposes of the benefits provided under this *Plan*, an alternate recipient shall be treated as an eligible *dependent*, but for purposes of the reporting and disclosure requirements under *ERISA*, an alternate recipient shall have the same status as a *plan participant*.

**Ambulatory Surgical Center**

A licensed facility that is used mainly for performing *outpatient surgery*, has a staff of *physicians*, has continuous *physician* and nursing care by registered nurses (R.N.s), and does not provide for overnight stays.

**Appeal**

A review by the *Plan* of an *adverse benefit determination*, as required under the *Plan's* internal *claims* and appeals procedures.

**Applied Behavioral Analysis (ABA) Therapy**

Applied Behavioral Analysis (ABA) Therapy is an umbrella term describing principles and techniques used in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors. The goal of ABA Therapy is to teach new skills, promote generalization of these skills, and reduce challenging behaviors with systematic reinforcement. ABA Therapy is a combination of services for adaptive behavior treatment, which applies the principles of how people learn and motivations to change behavior. ABA Therapy is designed to address multiple areas of behavior and function such as to increase language and communication, enhance attention and focus, and help with social skills and memory. It generally includes psychosocial interventions, should address factors that may exacerbate behavioral challenges, and is most effective when initiated as soon as feasible after diagnosis is made.

**Approved Clinical Trial**

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

1. The study or investigation is approved or funded by one (1) or more of the following:
    a. The National Institutes of Health
    b. The Centers for Disease Control and Prevention
    c. The Agency for Health Care Research and Quality
    d. The Centers for Medicare and Medicaid Services
    e. a cooperative group or center of any of the entities described in sub-clauses a. through d. above, the Department of Defense, or the Department of Veterans Affairs
    f. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    g. any of the following if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by *qualified individuals* who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs
        ii. The Department of Defense
        iii. The Department of Energy
2. The study or investigation is conducted under an *investigational* new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an *investigational* new drug application.

**Assignment of Benefits**

An arrangement by which a patient requests that their health benefit payments under this *Plan* be made directly to a designated medical provider or facility. By completing an assignment of benefits, the *plan participant* authorizes the *Plan Administrator* to forward payment for a covered procedure directly to the treating medical provider or facility. The *Plan Administrator* expects an assignment of benefits form to be completed, as between the *plan participant* and the provider.

**Authorized Representative**

An authorized representative is a person or organization a *plan participant* has designated to act on their behalf to submit or *appeal* a *claim*. By authorizing a person or organization to act on your behalf, you are giving them permission to see your protected health information (PHI) and act on all matters related to your *claim* and/or *appeal*. If you choose to authorize a person to act on your behalf, all future communications shall be with the designee. However, where an *urgent care claim* is involved, a health care professional with

knowledge of the medical condition will be permitted to act as a *claimant's* authorized representative without a prior written authorization.

**Balance Bill/Surprise Bill**

Balance bill refers to the difference between a *non-network provider's* total billed charges and the *allowable charges* off of which the *Plan* will base its reimbursement.

*Non-network providers* have no obligation to accept the *allowable charge* as payment in full. You are responsible to pay a *non-network provider's* billed charges, even though the *Plan's* reimbursement is based on the *allowable charge*. Any amounts paid for balance bills do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

Refer to the **Consolidated Appropriations Act of 2021 Notice and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* surprise billing *claims*.

**Benefit Determination**

The *Plan's* decision regarding the acceptance or denial of a *claim* for benefits under the *Plan*.

**Birthing Center**

Any freestanding health facility, place, professional office, or *institution* which is not a *hospital* or in a *hospital*, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.

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

**Blue Distinction Center**

See *Center of Medical Excellence*.

**Brand Name Drug**

A trade name medication.

**Calendar Year/Benefit Year**

January 1st through December 31st of the same year. All *deductibles* and benefit maximums accumulate during the calendar year.

**Cellular Immunotherapy**

A type of therapy that uses substances to stimulate or suppress the immune system to help the body fight cancer, infection, and other diseases. Some types of immunotherapy only target certain cells of the immune system. Others affect the immune system in a general way. Types of immunotherapy include cytokines, vaccines, bacillus Calmette-Guerin (BCG), and some monoclonal antibodies.

**Center of Medical Excellence**

*Medical care facilities* that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The *Plan Administrator* shall determine what *network* Centers of Excellence are to be used.

Any *plan participant* in need of an organ transplant may contact MyQHealth Care Coordinators as outlined in the Quick Reference Information Chart to initiate the *pre-certification* process resulting in a referral to a Center of Medical Excellence. MyQHealth Care Coordinators acts as the primary liaison with the Center of Medical Excellence, patient, and attending *physician* for all transplant admissions taking place at a Center of Medical Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to *plan participant(s)* and updated as requested.

**Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)**

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

**Claim**

Any request for a *Plan* benefit, made by a *claimant* or by a representative of a *claimant*, in accordance with a *Plan's* reasonable procedure for filing benefit claims.

Some requests made to the *Plan* are specifically not claims for benefits; for example:

1. an inquiry as to eligibility which does not request benefits
2. a request for prior approval where prior approval is not required by the *Plan*
3. casual inquiries about benefits such as verification of whether a service/item is a covered benefit or the estimated cost for a service

**Claimant**

Any *plan participant* or beneficiary making a *claim* for benefits. Claimants may file *claims* themselves or may act through an *authorized representative*. In this document, the words 'you' and 'your' are used interchangeably with 'claimant.'

**Claims Administrator**

AmeriBen has been hired as the Claims Administrator by the *Plan Administrator* to perform *claims* processing and other specified administrative services in relation to the *Plan*. The Claims Administrator is not an insurer of health benefits under this *Plan*, is not a fiduciary of the *Plan*, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*. The Claims Administrator is not responsible for *Plan* financing and does not guarantee the availability of benefits under this *Plan*.

**Clean Claim**

A *claim* that can be processed in accordance with the terms of this plan document without obtaining additional information from the service *provider* or a third party. It is a *claim* which has no defect, impropriety, or special circumstance that delays timely payment. A clean *claim* does not include:

1. *claims* under investigation for fraud and abuse
2. *claims* under review for *medical necessity*
3. fees under review for usual and customariness and *reasonableness*
4. any other matter that may prevent the expense(s) from being considered a *covered charge*

The claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A *claim* will not be considered to be a clean claim if the *participant* has failed to submit required forms or additional information to the *Plan* as well.

**Co-Insurance**

The portion of medical expenses (after the *deductible* has been satisfied) for which a *plan participant* is responsible.

**Complications of Pregnancy**

Complications of pregnancy result from conditions requiring *hospital* confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a complication of pregnancy.

Complications of pregnancy shall not include false labor, caesarean section, occasional spotting, *physician* prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as complications of pregnancy.

**Concurrent Care Claim**

A *Plan* decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

**Co-Payment**

A specific dollar amount a *plan participant* is required to pay and is typically payable to the health care provider at the time services or supplies are rendered.

**Cost Sharing Amounts**

The dollar amount a *plan participant* is responsible for paying when covered services are received from a provider. Cost sharing amounts include *co-insurance*, *co-payments*, *deductible* amounts, and *out-of-pocket limits*. Providers may bill you directly or request payment of *co-insurance* and/or *co-payments* at the time services are provided. Refer to the applicable Schedules of Benefits for the specific cost sharing amounts that apply to this *Plan*.

**Courtesy Review**

A pre-service review of requested services for benefits which are neither on the *pre-certification* list nor an exclusion of the *Plan*.

**Covered Charges**

The *maximum allowable charge* for a *medically necessary* service, treatment, or supply, meant to improve a condition or *plan participant's* health, which is eligible for coverage in this *Plan*. Covered charges will be determined based upon all other *Plan* provisions. When more than one (1) treatment option is available, and one (1) option is no more effective than another, the covered charge is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the applicable **Schedule of Benefits** section and as determined elsewhere in this document.

**Custodial Care**

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

**Deductible**

A specified portion of the *covered charges* that must be *incurred* by a *plan participant* before the *Plan* has any liability.

**Dependent**

For information regarding eligibility for dependents, refer to the *Plan's* wrap document.

**Dentist**

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

**Developmental Delay**

A delay in the appearance of normal developmental milestones achieved during infancy and early childhood, caused by organic, psychological, or environmental factors. Conditions are marked by delayed development or functional limitations especially in learning, language, communication, cognition, behavior, socialization, or mobility.

**Diagnostic Service**

A test or procedure performed for specified symptoms to detect or to monitor a *disease* or condition. It must be ordered by a *physician* or other professional provider.

**Disease**

Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the *Plan* is furnished showing that the individual concerned is covered as an *employee* under any workers' compensation law, occupational disease law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one (1) not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the *Plan*, be regarded as a *sickness*, *illness*, or disease.

**Diagnosis Related Grouping (DRG)**

A method for reimbursing *hospitals* for *inpatient* services. A DRG amount can be higher or lower than the actual billed charge because it is based on an average for that grouping of diagnoses and procedures.

**Durable Medical Equipment (DME)**

Equipment which is ordered by a *physician* and can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an *illness* or *injury*, and is appropriate for use in the home.

**Emergency**

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

**Emergency Services**

A medical screening examination [as required under Section 1867 of the Social Security Act (EMTALA)] within the capability of the *hospital* emergency department, including routine ancillary services, to evaluate a *medical emergency* and such further medical examination and treatment as are within the capabilities of the staff and facilities of the *hospital* and required under EMTALA to stabilize the patient.

**Employee**

For information regarding eligibility for employees, refer to the *Plan's* wrap document.

**Employer**

Refer to the *Plan's* wrap document.

**Enrollment Date**

The first day of coverage, or if there is a *waiting period*, the first day of the *waiting period*.

**Essential Health Benefits**

Benefits set forth under the *Patient Protection and Affordable Care Act of 2010* (*PPACA*), including the categories listed in the state of Utah benchmark plan.

**Experimental/Investigational**

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

The *Plan Administrator* must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The *Plan Administrator* shall be guided by a reasonable interpretation of *Plan* provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the *claim* and the proposed treatment. The decision of the *Plan Administrator* will be final and binding on the *Plan*. The *Plan Administrator* will be guided by the following principles, any of which comprise a definition of experimental/investigational:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished
2. if the drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval
3. if reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going Phase I or Phase II clinical trials, is the research, experimental study, or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis

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

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

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

Benefits covered under the Clinical Trials provision are not considered experimental or investigational.

The *Plan Administrator* has the discretion to determine which drugs, services, supplies, care, and/or treatments are considered experimental, investigative, or unproven.

If a drug, device, medical treatment, or other procedure is reviewed and recommended under the Personal Precision Oncology Management (PPOM) program, Quantum Health will be guided by the written guidelines and principles adopted by the *Plan Administrator* as part of the PPOM program in determining whether a drug, device, medical treatment, or other procedure will be deemed to be experimental and/or investigational.

**Explanation of Benefits (EOB)**

A document sent to the *plan participant* by the *Claims Administrator* after a *claim* for reimbursement has been processed. It includes the patient's name, claim number, type of service, provider, date of service, charges submitted for the services, amounts covered by this *Plan*, non-covered services, *cost sharing amounts*, and the amount of the charges that are the *plan participant's* responsibility. This form should be carefully reviewed and kept with other important records.

**External Review**

A review of an *adverse benefit determination*, including a *final internal adverse benefit determination*, under applicable state or federal external review procedures.

**Fiduciary**

A fiduciary exercises discretionary authority or control over management of the *Plan* or the disposition of its assets, renders investment advice to the *Plan*, or has discretionary authority or responsibility in the administration of the *Plan*.

**Family Unit**

The covered *employee* and the family members who are covered as *dependents* under the *Plan*.

**Final Internal Adverse Benefit Determination**

An *adverse benefit determination* that has been upheld by the *Plan* at completion of the *Plan's* internal *appeals* procedures; or an *adverse benefit determination* for which the internal *appeals* procedures have been exhausted under the deemed exhausted rule contained in the *appeals* regulations. For plans with two (2) levels of *appeals*, the second-level *appeal* results in a final internal adverse benefit determination that triggers the right to *external review*.

**FMLA Leave**

A *leave of absence* which the *employer* is required to extend to an *employee* under the provisions of the *FMLA*.

**Formulary**

A list of prescription medications compiled by the third-party payer of safe and effective therapeutic drugs specifically covered by this *Plan*.

**Foster Child**

A child under the limiting age shown in the **Eligibility** section of this *Plan* for whom a covered *employee* has assumed a legal obligation in connection with the child's placement with a state, county, or private foster care agency.

A covered foster child is not a child temporarily living in the covered *employee's* home; one placed in the covered *employee's* home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

**Gene Therapy**

Human gene therapy seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use. It is a technique that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms:

1. replacing a disease-causing gene with a healthy copy of the gene
2. inactivating a disease-causing gene that is not functioning properly
3. introducing a new or modified gene into the body to help treat a disease

**Generic Drug**

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

**Genetic Information**

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

The *Plan* complies with Title I of the *Genetic Information Nondiscrimination Act of 2008 (GINA)* as it applies to group health plans.

**Habilitative Services/Habilitation Services**

Treatment and services that help a *plan participant* keep, learn, or improve skills and functions for daily living that they may not be developing as expected for their age range. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

**Health Savings Account (HSA)**

A tax-exempt or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you *incur*. You must be eligible to qualify for an HSA (refer to the **Schedule of Benefits** section of this document). Both *employer* and *employee* may contribute to an *HSA* in the same year. Annual contribution limits are subject to IRS guidelines. Participation in a qualified *high deductible health plan* is required for participation in an *HSA* program. For more information, refer to the *Plan's* wrap document.

**High Deductible Health Plan (HDHP)**

A medical plan with lower premiums and a minimum *deductible* amount, set forth by federal law, which is higher than a traditional health plan *deductible*.

**Home Health Care Agency**

An organization that meets all of these tests: its main function is to provide *home health care services and supplies*; it is federally certified as a home health care agency; and it is licensed by the state in which it is located, if licensing is required.

**Home Health Care Plan**

Must meet these tests: it must be a formal written plan made by the patient's attending *physician* which is reviewed at least every thirty (30) days; it must state the diagnosis; it must certify that the home health care is in place of *hospital* confinement; and it must specify the type and extent of *home health care services and supplies* required for the treatment of the patient.

**Home Health Care Services and Supplies**

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

**Hospice Care Agency**

An organization whose main function is to provide *hospice care services and supplies* and is licensed by the state in which it is located, if licensing is required.

**Hospice Care Plan**

A plan of terminal patient care that is established and conducted by a *hospice care agency* and supervised by a *physician*.

**Hospice Care Services and Supplies**

Provided through a *hospice care agency* and under a *hospice care plan* and includes *inpatient* care in a *hospice unit* or other licensed facility, home health care, and family counseling during the bereavement period.

**Hospice Unit**

A facility or separate *hospital* unit that provides treatment under a *hospice care plan* and admits at least two (2) unrelated persons who are expected to die within six (6) months.

**Hospital (Acute or Long-Term Acute Care Facility)**

A provider licensed and operated as required by law, which provides all of the following and is fully accredited by The Joint Commission:

1. room, board, and nursing care
2. a staff with one (1) or more doctors on hand at all times
3. twenty-four (24) hour nursing service
4. all the facilities on site are needed to diagnose, care, and treat an *illness* or *injury*

The term hospital does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. custodial care
6. educational care
7. subacute care

Refer to the defined terms for *Residential Treatment Facility* and *Substance Use Disorder/Mental Health Treatment Center* for the specific requirements applicable to those facility types.

**Illness**

A bodily disorder, congenital defects, *disease*, physical illness, or *mental disorder*. Includes *pregnancy*, childbirth, miscarriage, or *complications of pregnancy*.

**Incurred**

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

**Independent Review Organization (IRO)**

An entity that performs independent *external reviews* of *adverse benefit determinations* and *final internal adverse benefit determinations*.

**Infertility**

The condition of a presumably healthy *plan participant* who is unable to conceive or produce conception after a period of one (1) year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

**Ineligible Charges**

Charges for health care services that are not *covered charges* because the services are not *medically necessary, pre-certification* was not obtained, benefits are not specifically provided under the *Plan*, are excluded by the *Plan*, are provided by an ineligible provider, or are otherwise not eligible to be *covered charges*, whether or not they are *medically necessary*.

**Injury**

An *accidental bodily injury*, which does not arise out of, which is not caused or contributed by, and which is not a consequence of, any employment or occupation for compensation or profit.

**Inpatient**

Treatment in an approved facility during the period when charges are made for *room and board*.

**Institution**

A facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a *hospital*, *ambulatory surgical center*, *psychiatric hospital*, community mental health center, *residential treatment facility*, psychiatric treatment facility, *substance use disorder treatment center*, alternative *birthing center*, home health care center, or any other such facility that the *Plan* approves.

**Intensive Care Unit**

A separate, clearly designated service area which is maintained within a *hospital* solely for the care and treatment of patients who are critically *ill*. This also includes what is referred to as a coronary care unit or an acute care unit. It has facilities for special nursing care not available in regular rooms and wards of the *hospital*; special lifesaving equipment which is immediately available at all times; at least two (2) beds for the accommodation of the critically *ill*; and at least one (1) registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

**In-Network**

See *Network*.

**Investigational**

See *Experimental/Investigational*.

**Late Enrollee**

A *plan participant* who enrolls under the *Plan* other than during the first thirty (30) day period in which the individual is eligible to enroll under the *Plan* or during a special enrollment period.

**Leave of Absence**

A period of time during which the *employee* does not work, but which is of a stated duration, after which time the *employee* is expected to return to active work.

**Legal Guardian**

A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

**Life-Threatening Disease or Condition**

Any *disease* or condition from which the likelihood of death is probable unless the course of the *disease* is interrupted.

**Long Term Acute Care Hospitals**

Facilities that specialize in the treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures.

**Long Term Care**

Generally refers to non-medical care for patients who need assistance with basic daily activities such as dressing, bathing, and using the bathroom. Long-term care may be provided at home or in facilities that include nursing homes and assisted living.

**Maintenance Care**

Therapy or treatment intended primarily to maintain general physical conditions, including, but not limited to routine, long-term, or maintenance care which is provided after the resolution of an acute medical problem. This includes services performed solely to preserve the present level of function or prevent regression for an *illness*, *injury*, or condition that is resolved or stable.

**Mastectomy**

The surgical removal of all or part of a breast.

**Maximum Amount or Maximum Allowable Charge**

The benefit payable for a specific coverage item or benefit under the *Plan*. Maximum allowable charge(s) will be based on one (1) of the following options, depending on the circumstances of the *claim* and at the discretion of the *Plan Administrator*:

1. *network* allowed amount
2. 125% of the *Medicare* rate for dialysis *claims*
3. *network non-participating provider* rate
4. the negotiated rate established in a contractual arrangement with a provider
5. the *usual and customary* and/or *reasonable* amount
6. the actual billed charges for the covered services

The maximum allowed amount for emergency care from a *non-network* provider will be determined using the median plan *network* contract rate paid to *network* providers for the geographic area where the service is provided.

The *Plan* has the discretionary authority to decide if a charge is usual and customary and/or *reasonable* for a *medically necessary* service. The maximum allowable charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

**Maximum Benefit**

Any one (1) of the following, or any combination of the following:

1. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* during the entire time he or she is covered by this *Plan*
2. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* for a particular *covered charge*

   The *maximum amount* can be for either of the following:

   a. the entire time the *plan participant* is covered under this *Plan*
   b. a specified period of time, such as a *calendar year*
3. the maximum number as outlined in the *Plan* as a *covered charge*

   The maximum number relates to the number of:

   a. treatments during a specified period of time
   b. days of confinement
   c. visits by a *home health care agency*

**Medical Care Facility**

A *hospital*, a facility that treats one (1) or more specific ailments, or any type of *skilled nursing facility*.

**Medical Child Support Order**

Any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that mandates one (1) of the following:

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

**Medical Emergency**

A medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child)
2. serious impairment to body functions
3. serious dysfunction of any body organ or part

A medical emergency includes such conditions as: heart attacks, cardiovascular *accidents*, poisonings, loss of consciousness or respiration, convulsions, or other such acute medical conditions.

**Medical Non-Emergency Care**

Care which can safely and adequately be provided other than in a *hospital*.

**Medically Necessary/Medical Necessity**

Care and treatment which is recommended or approved by a *physician* or *dentist*; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a *physician* recommends or approves certain care does not mean that it is medically necessary.

The *Plan Administrator* has the discretionary authority to decide whether care or treatment is medically necessary.

**Medicare**

The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

**Mental Disorder and Nervous Disorders/Substance Use Disorder**

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

**Mental Health or Substance Use Disorder Hold**

An involuntary detainment, by an officer of the court, in an *inpatient facility*, of an individual who is either posing a danger to themselves or others, or determined to be gravely disabled due to a mental health condition. Typically lasting up to seventy-two (72) hours.

**Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)**

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and *mental health* or *substance use disorder* benefits, such plan or coverage shall ensure all of the following:

1. The financial requirements applicable to such *mental health* or *substance use disorder* benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to *mental health* or *substance use disorder* benefits (if these benefits are covered by the group health *Plan* or health insurance coverage is offered in connection with such a plan).

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

**Network**

An arrangement under which services are provided to *plan participants* through a select group of providers.

**No-Fault Auto Insurance**

The basic reparations provision of a law providing for payments without determining fault in connection with automobile *accidents*.

**Non-Network**

Services rendered by a non-*participating provider* within the designated *network* area.

**Non-Participating Provider**

A health care practitioner or health care facility that has not contracted directly with the *Plan*, *network*, or an entity contracting on behalf of the *Plan* to provide health care services to *plan participants*.

**Notice/Notify/Notification**

The delivery or furnishing of information to a *claimant* as required by federal law.

**Open Enrollment Period**

The annual period during which you and your *dependents* are eligible to enroll for coverage or change benefit plan options.

**Other Plan**

Shall include but is not limited to:

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

**Out-of-Network**

See *Non-Network*.

**Out-of-Pocket Limit**

A *Plan's* limit on the amount a *plan participant* must pay out of their own pocket for medical expenses *incurred* during a *calendar year*. Out-of-pocket limits accumulate on an individual, family, or combined basis. After a *plan participant* reaches the out-of-pocket limit, the *Plan* pays benefits at a higher rate.

**Outpatient**

Treatment including services, supplies, and medicines provided and used at a *hospital* under the direction of a *physician* to a person not admitted as a registered bed patient; or services rendered in a *physician's* office, laboratory, or x-ray facility, an *ambulatory surgical center*, or the patient's home.

**Partial Hospitalization**

Structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than six (6) hours per day, five (5) days per week.

**Participating Provider**

A health care provider or health care facility that has contracted directly with the *Plan* or an entity contracting on behalf of the *Plan* to provide health care services to *plan participants*.

**Patient Protection and Affordable Care Act of 2010 (PPACA)**

The Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Jointly, these laws are referred to as PPACA.

**Pharmacy**

A licensed establishment where covered *prescription drugs* are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

**Physician**

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

**Plan**

Worthington Industries Group Welfare Plan, which is a benefits plan for certain *employees* of Worthington Industries, Inc. and is described in this document. Worthington Industries Group Welfare Plan is a distinct entity, separate from the legal entity that is your *employer*.

**Plan Administrator**

Worthington Industries, Inc., which is the named fiduciary of the *Plan*, and exercises all discretionary authority and control over the administration of the *Plan* and the management and disposition of *Plan* assets.

**Plan Participant/Participant**

Refer to the *Plan's* wrap document.

**Plan Sponsor**

Worthington Industries, Inc.

**Plan Year**

Refer to the *Plan's* wrap document.

**Post-Service Claim**

Any *claim* for a benefit under the *Plan* related to care or treatment that the *plan participant* or beneficiary has already received.

**Pre-Admission Tests/Testing**

Those *diagnostic services* done prior to scheduled *surgery*, provided that all of the following conditions are met:

1. The tests are approved by both the *hospital* and the *physician*.
2. The tests are performed on an *outpatient* basis prior to *hospital* admission.
3. The tests are performed at the *hospital* into which confinement is scheduled, or at a qualified facility designated by the *physician* who will perform the *surgery*.

**Pre-Certification/Pre-Certified**

An evaluation conducted by a utilization review team through the Care Coordination Program to determine the *medical necessity* and *reasonableness* of a *plan participant's* course of treatment.

**Pregnancy**

Childbirth and conditions associated with pregnancy, including complications.

**Prescription Drug**

Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed *physician*. Such drug must be *medically necessary* in the treatment of an *illness* or *injury*.

**Pre-Service Claim**

Any *claim* that requires *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* (e.g. a request for *pre-certification* under the Care Coordination Program).

**Preventive Care**

Certain preventive services mandated under the *Patient Protection and Affordable Care Act of 2010 (PPACA)* which are available without cost sharing when received from a *network* provider. To comply with *PPACA*, and in accordance with the recommendations and guidelines, the *Plan* will provide *network* coverage for:

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

Copies of the recommendations and guidelines may be found here: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**. For more information, you may contact the *Plan Administrator/employer* as outlined in the Quick Reference Information Chart.

**Prior Plan**

The coverage provided on a group or group-type basis by the group insurance policy, benefit plan, or service plan that was terminated on the day before the effective date of the *Plan* and replaced by the *Plan*.

**Prior to Effective Date or After Termination Date**

Dates occurring before a *plan participant* gains eligibility from the *Plan*, or dates occurring after a *plan participant* loses eligibility from the *Plan*, as well as charges *incurred* prior to the effective date of coverage under the *Plan* or after coverage is terminated, unless extension of benefits applies.

**Privacy Standards**

The standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

**Psychiatric Hospital**

An *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospitals*, which meets all of the following requirements:

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

The term psychiatric hospital does not include an *institution*, or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care*, or educational care.

**Qualified Individual**

An individual who is a covered *participant* or beneficiary in this *Plan* and who meets the following conditions:

1. the individual is eligible to participate in an *approved clinical trial* according to the trial protocol with respect to the treatment of cancer or other *life-threatening disease or condition*; and
2. either:
    a. The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.
    b. The *participant* or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.

**Qualified Medical Child Support Order (QMCSO)**

A *medical child support order* that creates or recognizes the existence of an *alternate recipient's* right to, or assigns to an *alternate recipient* the right to, receive benefits for which a *plan participant* or eligible *dependent* is entitled under this *Plan*.

**Reasonable**

In the *Plan Administrator's* discretion, services, supplies, or fees for services or supplies which are necessary for the care and treatment of *illness* or *injury* not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the *Plan Administrator*, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards, and practices as they relate to similar scenarios; and the cause of *injury* or *illness* necessitating the services and/or charges.

This determination will consider, but will not be limited to, the findings and assessments of the following entities:

1. The National Medical Associations, societies, and organizations
2. The Food and Drug Administration

To be reasonable, services and/or fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care, and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The *Plan Administrator* retains discretionary authority to determine whether services and/or fees are reasonable based upon information presented to the *Plan Administrator*. A finding of provider negligence and/or malpractice is not required for services and/or fees to be considered not reasonable.

Charges and/or services are not considered to be reasonable, and as such are not eligible for payment (exceed the *maximum allowable charge*), when they result from provider error(s) and/or facility-acquired conditions deemed reasonably preventable through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The *Plan* reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the *Plan* and to identify charges and/or services that are not reasonable, and therefore not eligible for payment by the *Plan*.

**Rehabilitation Hospital**

An *institution* which mainly provides therapeutic and restorative services to *ill* or *injured* people. It is recognized as such if it meets the following criteria:

1. It carries out its stated purpose under all relevant federal, state, and local laws.
2. It is accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities.

**Residential Treatment Center/Facility**

A provider licensed and operated as required by law, which includes:

1. room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with twenty-four (24) hour availability
2. a staff with one (1) or more doctors available at all times

3. residential treatment takes place in a structured facility-based setting
4. the resources and programming to adequately diagnose, care, and treat a psychiatric and/or substance use disorder
5. facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care
6. is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term residential treatment center/facility does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. custodial care
6. educational care

**Room and Board**

A *hospital's* charge for:

1. room and linen service
2. dietary service, including meals, special diets, and nourishment
3. general nursing service
4. other conditions of occupancy which are *medically necessary*

**Security Standards**

The final rule implementing HIPAA's security standards for the Protection of Electronic PHI, as amended.

**Sickness**

See *Disease*.

**Skilled Nursing Facility**

A facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an *inpatient* basis to persons recovering from an *injury* or *illness*. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a *physician*.
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, *custodial care*, or educational care.

This term also applies to charges *incurred* in a facility referring to itself as an extended acute rehabilitation facility, long-term acute care facility, or any other similar nomenclature.

**Sound Natural Tooth**

A tooth that is stable, functional, free from decay and advanced periodontal disease, and in good repair at the time of the accident.

**Specialty Drugs**

Typically high cost drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty drugs often require special handling such as temperature-controlled packaging and expedited delivery. Most specialty drugs require prior authorization to be considered *medically necessary*.

**Spinal Manipulation/Chiropractic Care**

Skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a *physician* to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

**Substance Abuse/Substance Use Disorder**

The DSM-5 definition is applied as follows: Substance use disorder describes a problematic pattern of using alcohol or another substance (whether obtained legally or illegally) that results in impairment in daily life or noticeable distress. An individual must display two (2) of the following eleven (11) symptoms within twelve (12) months:

1. consuming more alcohol or other substance than originally planned
2. worrying about stopping or consistently failed efforts to control one's use
3. spending a large amount of time using drugs/alcohol, or doing whatever is needed to obtain them
4. use of the substance results in failure to fulfill major role obligations such as at home, work, or school
5. craving the substance (alcohol or drug)
6. continuing the use of a substance despite health problems caused or worsened by it

   This can be in the domain of mental health (psychological problems may include depressed mood, sleep disturbance, anxiety, or blackouts) or physical health.
7. continuing the use of a substance despite its having negative effects in relationships with others (for example, using even though it leads to fights or despite people's objecting to it)
8. repeated use of the substance in a dangerous situation (for example, when having to operate heavy machinery, when driving a car)
9. giving up or reducing activities in a person's life because of the drug/alcohol use
10. building up a tolerance to the alcohol or drug

    Tolerance is defined by the DSM-5 as either needing to use noticeably larger amounts over time to get the desired effect or noticing less of an effect over time after repeated use of the same amount.
11. experiencing withdrawal symptoms after stopping use

    Withdrawal symptoms typically include, according to the DSM-5: anxiety, irritability, fatigue, nausea/vomiting, hand tremor or seizure in the case of alcohol.

**Substance Use Disorder/Mental Health Treatment Center**

An *institution* which provides a program for the treatment of *substance use disorder* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be at least one (1) of the following:

1. affiliated with a *hospital* under a contractual agreement with an established system for patient referral
2. accredited as such a facility by the Joint Commission or CARF
3. licensed, certified, or approved as an alcohol or *substance use disorder* treatment program center, *psychiatric hospital*, or *facility* for *mental health* by a state agency having legal authority to do so
4. is a facility operating primarily for the treatment of *substance use disorder* and meets these tests:
   a. maintains permanent and full-time facilities for bed care and full-time confinement of at least twenty-four (24) hour-per-day nursing service by a registered nurse (R.N.)
   b. has a full-time psychiatrist or psychologist on the staff
   c. is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of *substance use disorder*

**Surgery/Surgical Procedure**

Any of the following:

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

**Temporomandibular Joint (TMJ)**

The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves, and other tissues related to the temporomandibular joint.

**Timely Payment**

As referenced in the section entitled **Continuation Coverage Rights Under COBRA**. Timely payment means a payment made no later than thirty (30) days after the first day of the coverage period.

**Total Disability/Totally Disabled**

In the case of a *dependent* child, the complete inability, as a result of *injury* or *illness*, to perform the normal activities of a person of like age and sex and in good health.

**Uniformed Services**

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

**Urgent Care Facility**

A free-standing facility, regardless of its name, at which a *physician* is in attendance at all times that the facility is open, that is engaged primarily in providing minor *emergency* and episodic medical care to a *plan participant*.

**Urgent Care Claim**

Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an urgent care claim will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any *claim* that a *physician* with knowledge of the *claimant's* medical condition determines is an urgent care claim as described herein shall be treated as an urgent care claim under the *Plan*. Urgent care claims are a subset of *pre-service claims*.

**Usual and Customary Charge**

*Covered charges* which are identified by the *Plan Administrator*, taking into consideration the fees which the provider most frequently charges (or accepts) for the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same area by providers of similar training and experience for the service or supply, and the *Medicare* reimbursement rates. The term(s) 'same geographic locale' and/or 'area' shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons, or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be usual and customary, fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term ‘usual’ refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, *pharmacies*, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was *incurred*.

The term ‘customary’ refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one (1) individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale.

The term ‘usual and customary’ does not necessarily mean the actual charge made (or accepted), nor the specific service or supply furnished to a *plan participant* by a provider of services or supplies, such as a *physician*, therapist, nurse, *hospital*, or pharmacist. The *Plan Administrator* will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service, or supply is customary.

Usual and customary charges may, at the *Plan Administrator’s* discretion, alternatively be determined and established by the *Plan* using normative data such as, but not limited to, *Medicare* cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer’s retail pricing (MRP) for supplies and devices.

**Waiting Period**

An interval of time during which the *employee* is in the continuous, *active employment* of his/her participating *employer*.

If you have questions about your *Plan* benefits, please contact MyQHealth Care Coordinators at 1.888.971.7377.


P.O. Box 7186
Boise ID 83707