PREFERRED PROVIDER

PLAN OF BENEFITS

Dear Member:

Blue Cross and Blue Shield of Florida, Inc. (BCBSF) is pleased to provide administrative services for your Group Health Plan as outlined in this Preferred Provider Plan of Benefits. BCBSF provides you and your covered family members with cost-effective health care coverage administration both locally and on a nationwide basis.

Please refer to the Benefits outlined in this Plan of Benefits for all your health care coverage.

See your Member ID Card for specific phone numbers, including but not limited to:

- Customer Service
- Preauthorization
- Mental Health and Substance Use Disorder

TTY users please call:

- 800-735-8583

The Blue Cross and Blue Shield networks offer the best geographic access to Providers and Hospitals of any Preferred Provider Organization (PPO) in the nation. This national coverage is available through the BlueCard® Program in which all Blue Cross Plans participate. For more Provider information visit our website at www.MyHealthToolkitFL.com.

We welcome you to our family of health care coverage through BCBSF and look forward to meeting your health care administration needs.

BCBSF may utilize the services of BlueCross BlueShield of South Carolina to administer certain portions of this Benefit program.

Sincerely,

Blue Cross and Blue Shield of Florida, Inc.

Blue Cross and Blue Shield of Florida, Inc. is an Independent Licensee of the Blue Cross Blue Shield Association.

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE

Under this Plan of Benefits, the Benefits you receive will depend on whether the Provider of medical services is a Participating or Non-Participating Provider. You will receive the maximum Benefits that can be paid if you use Participating Providers and you get Preauthorization, when required, before getting medical care. The amount you have to pay will increase when you do not use Participating Providers and if you do not get Preauthorization.

Members of the Blue Cross and Blue Shield Association (BCBSA) attempt to contract with Providers that practice at participating Hospitals. For various reasons, some Providers may elect not to contract as Participating Providers. If you use a Non-Participating Provider, you have no protection from balance billing from the Provider.

Non-Participating Provider services will be paid as Participating Provider services when the nearest Participating Provider is more than fifty (50) miles from Member's home. Member claims will be processed as Non-Participating claims. Members should contact customer service for claims payment and adjustments related to this Benefit by using the contact information on your Member ID Card.

BCBSF (hereafter referred to as Corporation) is the claims administrator for this Preferred Provider Plan. BCBSF has retained BlueCross BlueShield of South Carolina as a primary provider of claims processing, customer service, medical management, and other services.

IMPORTANT INFORMATION

How to get help on Preauthorization:

For Magnetic Resonance Imaging (MRIs), Magnetic Resonance Angiography (MRAs), Computerized Axial Tomography (CAT) scans or Positron Emission Tomography (PET) scans in an outpatient facility:

- 866-500-7664

For all other medical care:

- 888-376-6544

Please do not call the above number(s) for claims inquiries.

Please note that Preauthorization is required for certain procedures. Please contact your Provider for additional information.

HOW TO FILE CLAIMS

Participating Providers have agreed to file claims for health care services they rendered to you. However, in the event a Provider does not file a claim for such services, it is your responsibility to file the claim. If you choose to use a Non-Participating Provider, you are responsible for filing your claim.

Once the claim has been processed, you will have quick access to an Explanation of Benefits (EOB) through our website or by contacting customer service. The EOB explains who provided the care, the kind of service or supply received, the amount billed, the Allowable Charge, the Coinsurance rate and the amount paid. It also shows Benefit Year Deductible information and the reasons for denying or reducing a claim.

The only time you must pay a Participating Provider is when you have a Benefit Year Deductible, Coinsurance, Copayment or when you have services or supplies that are not Covered Expenses under your Plan of Benefits.

If you need a claim form, you may obtain one from us at the address below or print a copy from the website. You can also call us at the number listed or website on your Identification Card and we will send you a form. After filling out the claim form, send it to the address below:

BlueCross BlueShield
P.O. Box 100121
Columbia, South Carolina 29202

Please refer to Article VIII of this Plan of Benefits for more information on filing a claim.

SCHEDULE OF BENEFITS

Employer Contract Number: 71-5969K-01 and appropriate subgroups
Employer: Fanatics, Inc.
PPO Option 2 Plan
Plan of Benefits Effective Date: July 1, 2020

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of the Plan of Benefits. In the event of a conflict between the Plan of Benefits and this Schedule of Benefits, the Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in the Plan of Benefits.

To maximize your Benefits, seek medical services from a Participating Provider who participates in the Preferred Provider Organization (PPO). Please call 800-810-2583 or access our website at www.MyHealthToolkitFL.com **to find out if your Provider is a Participating Provider.**

GENERAL PROVISIONS

When a Benefit is listed below and has a dollar or percentage amount associated with it then the Benefit will be provided to Members subject to the terms of this Plan of Benefits. When a Benefit has a "Covered" notation associated with it, the Benefit will pay based on the location of the service (e.g. inpatient, outpatient, office). When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to the Member. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.

Benefit Year Deductible:	$4,500 per family with no one Member meeting more than $1,500 for Participating Providers. $13,500 per family with no one Member meeting more than $4,500 for Non-Participating Providers. Covered Expenses for services rendered by Participating or Non-Participating Providers will be applied only to the Participating Provider Benefit Year Deductible or the Non-Participating Provider Benefit Year Deductible, respectively.
Out-of-Pocket Maximums:	$9,000 per family with no one Member meeting more than $4,500 for Participating Providers. $18,000 per family with no one Member meeting more than $9,000 for Non-Participating Providers. Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. If Coinsurance does not contribute to the Out-of-Pocket Maximum, the percentage of reimbursement does not change from the amount indicated on the Schedule of Benefits. Coinsurance, Benefit Year Deductibles and Copayments for services rendered by Participating or Non-Participating Providers will be applied only to the Participating Provider Out-of-Pocket Maximum or the Non-Participating Provider Out-of-Pocket Maximum, respectively.

This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Year. The Anniversary Date is 07/01.

PREAUTHORIZATION	
Inpatient	**All Admissions require Preauthorization** If Preauthorization is not obtained, and you or your dependents are still admitted, financial penalties may be assessed for failure to obtain Preauthorization for Participating Provider Admissions. If Preauthorization is not obtained or approved by the Corporation, there will be a 50% penalty of the Allowable Charges for Non-Participating Provider Admissions.
Outpatient	Preauthorization is required for certain outpatient Benefits. Please contact your Provider for additional information.
Mental Health Services and Substance Use Disorder Services	Preauthorization is required for certain Mental Health Services and Substance Use Disorder Services. Please contact your Provider for additional information. Benefits for ABA related to Autism Spectrum Disorder will be denied when Preauthorization is not obtained or approved by the Corporation. If Preauthorization is not obtained or approved by the Corporation for facility-based inpatient services, there will be a 50% penalty of the Allowable Charges for Non-Participating Provider Admissions.
Pharmacy	Please refer to the Corporation's website for a complete list of Specialty Drugs that require Preauthorization.

ADMISSIONS/INPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Hospital charges for room and board related to Admissions	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $500 Copayment The Member must pay the balance of the Provider's charge
All other Benefits in a Hospital during an Admission (including for example, facility charges related to the administration of anesthesia, obstetrical services including labor and delivery rooms, drugs, medicine, lab and X-ray services)	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $500 Copayment The Member must pay the balance of the Provider's charge
Inpatient physical rehabilitation services	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $500 Copayment The Member must pay the balance of the Provider's charge
Hospital Admission resulting from an emergency room visit	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Skilled Nursing Facility Admissions, limited to sixty (60) days per Member per Benefit Year	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

OUTPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Hospital and Ambulatory Surgical Center charges for Benefits provided on an outpatient basis, including: lab, X-ray and other diagnostic services	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient emergency room services (Copayment waived if admitted)	The Employer pays 100% of the Allowable Charge after the Member pays a $350 Copayment	The Employer pays 100% of the Allowable Charge after the Member pays a $350 Copayment The Member must pay the balance of the Provider's charge
Urgent care	The Employer pays 100% of the Allowable Charge after the Member pays a $30 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Surgery	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Maternity	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $500 Copayment The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Rehabilitation related to physical therapy and occupational therapy All rehabilitation services related to speech therapy, physical therapy, occupational therapy, chiropractic services, pulmonary rehabilitation, cardiac rehabilitation and cognitive therapy are limited to a combined thirty-five (35) visits per Member per Benefit Year	The Employer pays 100% of the Allowable Charge after the Member pays a $55 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation related to physical therapy and occupational therapy All habilitation services related to speech therapy, physical therapy and occupational therapy are limited to a combined thirty-five (35) visits per Member per Benefit Year	The Employer pays 100% of the Allowable Charge after the Member pays a $55 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Rehabilitation related to speech therapy All rehabilitation services related to speech therapy, physical therapy, occupational therapy, chiropractic services, pulmonary rehabilitation, cardiac rehabilitation and cognitive therapy are limited to a combined thirty-five (35) visits per Member per Benefit Year	The Employer pays 100% of the Allowable Charge after the Member pays a $55 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation related to speech therapy All habilitation services related to speech therapy, physical therapy and occupational therapy are limited to a combined thirty-five (35) visits per Member per Benefit Year	The Employer pays 100% of the Allowable Charge after the Member pays a $55 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Independent lab	The Employer pays 100% of the Allowable Charge	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

PROVIDER SERVICES OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Provider Services in a Hospital	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Surgical Services, when rendered in a Hospital or Ambulatory Surgical Center	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Provider Services for lab, X-ray and other diagnostic services	The Employer pays 100% of the Allowable Charge	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for rehabilitation related to physical therapy and occupational therapy All rehabilitation services related to speech therapy, physical therapy, occupational therapy, chiropractic services, pulmonary rehabilitation, cardiac rehabilitation and cognitive therapy are limited to a combined thirty-five (35) visits per Member per Benefit Year	The Employer pays 100% of the Allowable Charge	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Provider Services for habilitation related to physical therapy and occupational therapy All habilitation services related to speech therapy, physical therapy and occupational therapy are limited to a combined thirty-five (35) visits per Member per Benefit Year	The Employer pays 100% of the Allowable Charge	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for rehabilitation related to speech therapy All rehabilitation services related to speech therapy, physical therapy, occupational therapy, chiropractic services, pulmonary rehabilitation, cardiac rehabilitation and cognitive therapy are limited to a combined thirty-five (35) visits per Member per Benefit Year	The Employer pays 100% of the Allowable Charge	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for habilitation related to speech therapy All habilitation services related to speech therapy, physical therapy and occupational therapy are limited to a combined thirty-five (35) visits per Member per Benefit Year	The Employer pays 100% of the Allowable Charge	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider's Services in the office, including contraceptives and birth control devices* (excluding physical therapy, speech therapy and occupational therapy)	The Employer pays 100% of the Allowable Charge after the Member pays a $30 Copayment Office services by a Specialist will be paid at 100% of the Allowable Charge after a $55 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Rehabilitation in a Provider's office related to physical therapy and occupational therapy All rehabilitation services related to speech therapy, physical therapy, occupational therapy, chiropractic services, pulmonary rehabilitation, cardiac rehabilitation and cognitive therapy are limited to a combined thirty-five (35) visits per Member per Benefit Year	The Employer pays 100% of the Allowable Charge after the Member pays a $55 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation in a Provider's office related to physical therapy and occupational therapy All habilitation services related to speech therapy, physical therapy and occupational therapy are limited to a combined thirty-five (35) visits per Member per Benefit Year	The Employer pays 100% of the Allowable Charge after the Member pays a $55 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Rehabilitation in a Provider's office related to speech therapy All rehabilitation services related to speech therapy, physical therapy, occupational therapy, chiropractic services, pulmonary rehabilitation, cardiac rehabilitation and cognitive therapy are limited to a combined thirty-five (35) visits per Member per Benefit Year	The Employer pays 100% of the Allowable Charge after the Member pays a $55 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation in a Provider's office related to speech therapy All habilitation services related to speech therapy, physical therapy and occupational therapy are limited to a combined thirty-five (35) visits per Member per Benefit Year	The Employer pays 100% of the Allowable Charge after the Member pays a $55 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Allergy serum dispensed by a physician in the office	The Employer pays 100% of the Allowable Charge	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

*Contraceptives and birth control devices covered under the Affordable Care Act (ACA) will pay at 100% of the Allowable Charge at Participating Providers. No Benefits are payable at Non-Participating Providers.

MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Inpatient Hospital charges for Mental Health Services and Substance Use Disorder Services	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Inpatient Hospital Admission resulting from an emergency room visit for Mental Health Services and Substance Use Disorder Services	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Residential Treatment Center Admissions for Mental Health Services and Substance Use Disorder Services	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Hospital or clinic charges for Mental Health Services and Substance Use Disorder Services	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Inpatient Provider charges for Mental Health Services and Substance Use Disorder Services	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Outpatient or office Provider charges for Mental Health Services and Substance Use Disorder Services	The Employer pays 100% of the Allowable Charge after the Member pays a $30 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient emergency room services for Mental Health Services and Substance Use Disorder Services	The Employer pays 100% of the Allowable Charge after the Member pays a $350 Copayment	The Employer pays 100% of the Allowable Charge after the Member pays a $350 Copayment The Member must pay the balance of the Provider's charge

OTHER SERVICES			
	Blue Distinction® Center or Blue Distinction® Center+	**Participating Provider**	**Non-Participating Provider**
Human organ and tissue transplant services Provider charges are subject to the Benefit Year Deductible.	The Employer pays 100% of the Allowable Charge	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $500 Copayment The Member must pay the balance of the Provider's charge

	Participating Provider	**Non-Participating Provider**
Travel and lodging for covered human organ and tissue transplant services for recipients and their family members, limited to $10,000 per Member per lifetime	The Employer pays 100% of the Allowable Charge	The Employer pays 100% of the Allowable Charge The Member must pay the balance of the Provider's charge
Ambulance service (including air ambulance)	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Durable Medical Equipment, Prosthetics and Orthopedic Devices	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Hearing aids, limited to one (1) up to $500 per ear per Member every two (2) years	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hearing aid exams, limited to one (1) visit per Member per Benefit Year	Covered	Covered
Cochlear implants	Covered	Covered
Medical Supplies	Covered	Covered
Home Health Care, limited to ninety (90) days per Member per Benefit Year	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Private Duty Nursing, limited to sixty (60) days per Member per Benefit Year	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hospice Care	The Employer pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
ABA related to Autism Spectrum Disorder	Covered	Non-Covered

	Participating Provider	Non-Participating Provider
Allergy injections	The Employer pays 100% of the Allowable Charge after the Member pays a $10 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Acupuncture	The Employer pays 100% of the Allowable Charge after the Member pays a $55 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Chiropractic services All rehabilitation services related to speech therapy, physical therapy, occupational therapy, chiropractic services, pulmonary rehabilitation, cardiac rehabilitation and cognitive therapy are limited to a combined thirty-five (35) visits per Member per Benefit Year	The Employer pays 100% of the Allowable Charge after the Member pays a $55 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Obesity services	Covered	Covered
Morbid obesity services	Covered	Covered
Surgical Services for the treatment of morbid obesity	Non-Covered	Non-Covered
Nutritional counseling, limited to three (3) visits per Member per Benefit Year	Covered	Covered
Infertility treatment	Covered	Covered
Temporomandibular Joint Disorder (TMJ) including treatment	Covered	Covered
Orthognathic surgery (Please see the 'Orthognathic Surgery' section in Article II of the Plan of Benefits for limitations)	Covered	Covered

	Participating Provider	Non-Participating Provider
Advanced radiology imaging	The Employer pays 100% of the Allowable Charge after the Member pays a $250 Copayment	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Genetic counseling, limited to three (3) visits per Member per Benefit Year*	Covered	Covered

*The three (3) visit limit will not apply to Mental Health and Substance Abuse Use Disorders.

PREVENTIVE BENEFITS The Benefit Year Deductible does not apply to these Benefits		
	Participating Provider	**Non-Participating Provider**
Preventive Benefits under the Affordable Care Act (ACA) (Refer to www.healthcare.gov for guidelines)	Covered	Non-Covered

SUSTAINED HEALTH SERVICES This Benefit does not include preventive Benefits offered under the Affordable Care Act (ACA). Payment will be made for the ACA preventive Benefits prior to Sustained Health services. See the preventive Benefits section in this Schedule of Benefits for payment of preventive Benefits under the ACA.		
	Participating Provider	**Non-Participating Provider**
Pap smear screenings (the report and interpretation only), limited to one (1) per Member per Benefit Year	The Employer pays 100% of the Allowable Charge	Covered
Physical exam, including well women exams, limited to one (1) per Member per Benefit Year	The Employer pays 100% of the Allowable Charge	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Prostate screenings, limited to one (1) per Member per Benefit Year	The Employer pays 100% of the Allowable Charge	Covered
Well Child Care performed in the Provider's office and immunizations for dependents	The Employer pays 100% of the Allowable Charge	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Immunizations	The Employer pays 100% of the Allowable Charge	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Flu shots, including Flu Mist	The Employer pays 100% of the Allowable Charge	The Employer pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Routine bone density screenings	The Employer pays 100% of the Allowable Charge	Covered
Routine or diagnostic colonoscopies*	The Employer pays 100% of the Allowable Charge	Covered
Mammography screenings, for any female Member age forty (40) or older*	The Employer pays 100% of the Allowable Charge	Covered
Diagnostic mammography screenings*	The Employer pays 100% of the Allowable Charge	Covered

*Benefits performed due to family history of colon cancer or breast cancer will be covered regardless of age or frequency limit.

TABLE OF CONTENTS

ARTICLE I - DEFINITIONS 1

ARTICLE II - BENEFITS 14

A. PAYMENT 14
B. PREAUTHORIZATION 14
C. SPECIFIC COVERED BENEFITS 15
D. BENEFITS 15
ABA RELATED TO AUTISM SPECTRUM DISORDER 15
ACUPUNCTURE 15
ALLERGY SERUM 15
AMBULANCE SERVICES 16
CARDIAC REHABILITATION 16
CHIROPRACTIC SERVICES 16
CLEFT LIP OR PALATE 17
CLINICAL TRIALS 17
COCHLEAR IMPLANTS 17
COGNITIVE THERAPY 17
DENTAL CARE FOR ACCIDENTAL INJURY 18
DIABETES EDUCATION 18
DURABLE MEDICAL EQUIPMENT 18
EMERGENCY SERVICES 18
GENDER DYSPHORIA 18
GENETIC COUNSELING 18
GYNECOLOGICAL EXAMINATION 18
HABILITATION 18
HEARING AIDS AND EXAMS 19
HOME HEALTH CARE 19
HOSPICE CARE 19
HOSPITAL SERVICES 19
HUMAN ORGAN AND TISSUE TRANSPLANTS 19
IN-HOSPITAL MEDICAL SERVICE 20
INFERTILITY 20
MAMMOGRAPHY TESTING 20
MEDICAL SUPPLIES 21
MENTAL HEALTH SERVICES 21
NUTRITIONAL COUNSELING 21
OBESITY RELATED PROCEDURES 21
OBSTETRICAL SERVICES 21
ORTHOGNATHIC SURGERY 21
ORTHOPEDIC DEVICES 21
ORTHOTIC DEVICES 22
OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES 22
OUTPATIENT REHABILITATION SERVICES 22
OXYGEN 22
PAP SMEAR 22
PHYSICAL EXAMINATION 22
PREVENTIVE SERVICES 22
PRIVATE DUTY NURSING 22
PROSTATE EXAMINATION 23
PROSTHETIC DEVICES 23
PROVIDER SERVICES 23
PULMONARY REHABILITATION 23

RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES 23
REHABILITATION 23
RESIDENTIAL TREATMENT CENTERS 24
SKILLED NURSING FACILITY SERVICES 24
SPECIALTY DRUGS 24
SPEECH THERAPY 24
SUBSTANCE USE DISORDER SERVICES 25
SURGICAL SERVICES 25
SUSTAINED HEALTH BENEFITS 26
TELEHEALTH 26
TELEMEDICINE 26
TEMPOROMANDIBULAR JOINT (TMJ) DISORDER 27
VARICOSE VEIN AND VENOUS INSUFFICIENCY TREATMENT 27

ARTICLE III - EXCLUSIONS AND LIMITATIONS 27

ACTS OF WAR 27
ADMISSIONS THAT ARE NOT PREAUTHORIZED 27
AMBULANCE 27
AUTO ACCIDENTS 28
BEHAVIORAL, EDUCATIONAL OR ALTERNATE THERAPY PROGRAMS 28
BENEFITS PROVIDED BY STATE OR FEDERAL PROGRAMS 28
COMPLICATIONS FROM NON-COVERED SERVICES 28
CONTRACEPTIVES 28
COPYING CHARGES 29
COSMETIC AND RECONSTRUCTIVE SERVICES 29
CRANIAL ORTHOTICS 29
CUSTODIAL CARE 29
DENTAL SERVICES 29
EYEGLASSES 30
FOOD SUPPLEMENTS 30
FOOT CARE 30
HAIR REPLACEMENTS 30
HUMAN ORGAN AND TISSUE TRANSPLANTS 30
HYPNOTISM 30
ILLEGAL ACTS 30
IMPACTED TOOTH REMOVAL 30
IMPOTENCE 30
INCAPACITATED DEPENDENTS 30
INPATIENT DIAGNOSTIC AND EVALUATIVE PROCEDURES 31
INTOXICATION OR DRUG USE 31
INVESTIGATIONAL OR EXPERIMENTAL SERVICES 31
LIFESTYLE IMPROVEMENT SERVICES 31
LONG-TERM CARE SERVICES 31
MEMBERSHIP DUES AND OTHER FEES 31
MOTORIZED WHEELCHAIRS OR POWER OPERATED VEHICLES 31
NOT MEDICALLY NECESSARY SERVICES OR SUPPLIES 32
OBESITY RELATED PROCEDURES 32
ORTHOGNATHIC SURGERY 32
OUTPATIENT SERVICES THAT ARE NOT PREAUTHORIZED 32
OVER-THE-COUNTER DRUGS 32
PAIN MANAGEMENT 32
PARTICIPATING PROVIDER CHARGES NOT PREAUTHORIZED 33
PHYSICAL THERAPY ADMISSIONS 33
PREOPERATIVE ANESTHESIA CONSULTATION 33
PRESCRIPTION DRUG COPAY CARD 33

PRESCRIPTION DRUGS 33
PROVIDER CHARGES 33
PSYCHOLOGICAL AND EDUCATIONAL TESTING 33
PULMONARY REHABILITATION 33
RADIOLOGY MANAGEMENT 33
REPATRIATION 33
SELF-INFLICTED INJURY 33
SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS 34
SERVICES FOR COUNSELING OR PSYCHOTHERAPY 34
SERVICES NOT LISTED AS COVERED BENEFITS 34
SERVICES PRIOR TO MEMBER EFFECTIVE DATE OR PLAN OF BENEFITS EFFECTIVE DATE 34
SERVICES RENDERED BY FAMILY 34
SEX CHANGE 34
TEMPOROMANDIBULAR JOINT (TMJ) DISORDER 34
TRAVEL 34
VISION CARE SERVICES 35
WORKERS' COMPENSATION/ON THE JOB INJURIES 35

ARTICLE IV - COORDINATION OF BENEFITS 35

A. APPLICABILITY 35
B. COORDINATION OF BENEFITS WITH AUTO INSURANCE 35
C. ORDER OF DETERMINATION RULES FOR EMPLOYEE MEMBERS 36
D. ADDITIONAL ORDER OF DETERMINATION RULES 36
E. EFFECT ON BENEFITS OF THIS PLAN OF BENEFITS 38
F. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION 38
G. PAYMENT 39
H. RIGHT OF RECOVERY 39

ARTICLE V – CONTINUATION OF COVERAGE 39

A. CONTINUATION 39
B. QUALIFIED MEDICAL CHILD SUPPORT ORDER 42

ARTICLE VI – SUBROGATION AND REIMBURSEMENT 44

A. BENEFITS SUBJECT TO THIS PROVISION 44
B. STATEMENT OF PURPOSE 44
C. DEFINITIONS 44
D. WHEN THIS PROVISION APPLIES 45
E. DUTIES OF THE MEMBER 46
F. FIRST PRIORITY RIGHT OF SUBROGATION AND/OR REIMBURSEMENT 47
G. WHEN A MEMBER RETAINS AN ATTORNEY 47
H. WHEN THE MEMBER IS A MINOR OR IS DECEASED OR INCAPACITATED 48
I. WHEN A MEMBER DOES NOT COMPLY 48
J. PRIOR RECOVERIES 48

ARTICLE VII - WORKERS' COMPENSATION PROVISION 49

ARTICLE VIII - CLAIMS FILING AND APPEAL PROCEDURES 50

A. CLAIMS FILING PROCEDURES 50
B. APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION 53
C. EXTERNAL REVIEW PROCEDURES 56

ARTICLE IX - GENERAL PROVISIONS 57

ADMINISTRATIVE SERVICES ONLY 57
AMENDMENT 57
AUTHORIZED REPRESENTATIVES 57
THE BLUECARD PROGRAM 57
CLERICAL ERRORS 66
DISCLOSURE OF PHI TO PLAN SPONSOR 66
EMPLOYER IS AGENT OF MEMBERS 68
GOVERNING LAW 68
IDENTIFICATION CARD 69
INFORMATION AND RECORDS 69
LEGAL ACTIONS 69
NEGLIGENCE OR MALPRACTICE 69
NOTICES 69
NO WAIVER OF RIGHTS 70
OTHER INSURANCE 70
PAYMENT OF CLAIMS 70
PHYSICAL EXAMINATION 70
REPLACEMENT COVERAGE 70

INDEX 71

ARTICLE I - DEFINITIONS

Capitalized terms that are used in this Plan of Benefits shall have the following defined meanings:

ACA: the Affordable Care Act of 2010, as amended.

Admission: the period of time between a Member's admission as a patient into a Hospital or Skilled Nursing Facility and the time the Member leaves or is discharged.

Adverse Benefit Determination: any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Plan, and including, a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which Benefits are otherwise provided because it is determined to be Investigational or Experimental or not Medically Necessary or appropriate. An Adverse Benefit Determination includes any cancellation or discontinuance of coverage that has retroactive effect (whether or not there is an adverse effect on any particular Benefit), except to the extent attributable to a failure to pay any required premiums or Employee contributions.

Allowable Charge: the amount the Corporation or a licensee of the Blue Cross Blue Shield Association (BCBSA) agrees to pay a Provider as payment in full for a service, procedure, supply or equipment. Additionally:

1. The Allowable Charge shall not exceed the Maximum Payment;

2. The Allowable Charge for Emergency Services provided by Non-Participating Providers will pay in accordance with the definition of Maximum Payment; and,

3. In addition to the Member's liability for Benefit Year Deductibles, Copayments and/or Coinsurance, the Member may be balance billed by the Non-Participating Provider for any difference between the Allowable Charge and the Billed Charge.

Alternate Recipient: any child who is recognized under a Medical Child Support Order as having a right to enroll in this Plan of Benefits.

Ambulatory Surgical Center: a licensed facility that:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;

2. Provides treatment by or under the supervision of licensed medical doctors or oral surgeons and provides nursing services when the Member is in the facility;

3. Does not provide inpatient accommodations; and,

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a licensed medical doctor or oral surgeon.

Applied Behavioral Analysis (ABA): behavioral modification to target cognition, language and social skills for Autism Spectrum Disorder.

Authorized Representative: an individual (including a Provider) whom the Member designates in writing to act on his or her behalf.

Autism Spectrum Disorder: the diagnoses designated as such in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Behavioral Health Provider: a Provider who renders Mental Health Services and/or Substance Use Disorder Services and is licensed to practice independently.

Behavioral Health Services: all Mental Health Services and/or Substance Use Disorder Services performed by a licensed Behavioral Health Provider.

Benefit Year: the period of time set forth on the Schedule of Benefits. The initial Benefit Year may be more or less than twelve (12) months.

Benefit Year Deductible: the amount, if any, listed on the Schedule of Benefits that must be paid by the Member each Benefit Year before the Group Health Plan will pay Covered Expenses. The Benefit Year Deductible is subtracted from the Allowable Charge before Coinsurance is calculated. Members must refer to the Schedule of Benefits to determine if the Benefit Year Deductible applies to the Out-of-Pocket Maximum.

Benefit(s): medical services or Medical Supplies that are:

1. Medically Necessary;

2. Preauthorized (when required under this Plan of Benefits or the Schedule of Benefits);

3. Included in Article II of this Plan of Benefits; and,

4. Not limited or excluded under the terms of this Plan of Benefits.

Benefits Checklist: the document (in electronic or hardcopy form) maintained by the Corporation which reflects the benefits selected by the Employer and submitted to the Corporation which outlines the Benefits to be offered under the Group Health Plan. The Corporation shall administer the Plan of Benefits in accordance with the terms of the Benefits Checklist. In the event of any conflict between the Benefits Checklist and this Plan of Benefits or the Schedule of Benefits, the Benefits Checklist shall control.

Billed Charges: the actual charges as billed by a Provider.

BlueCard Program: a program in which all members of the BCBSA participate. Details of the BlueCard Program are more fully set forth in Article IX.

Clinical Trials: an approved clinical trial is one that is approved or funded through the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS), the Department of Defense (DOD), the Department of Veterans Affairs (VA), a qualified non-governmental research entity identified in the guidelines issued by the NIH or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA).

COBRA: those provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended, which require certain Employers to offer continuation of healthcare coverage to Employees and dependents of Employees who would otherwise lose coverage.

COBRA Administrator: the Corporation or its designated subcontractor that provides administrative services related to COBRA.

Coinsurance: the sharing of the Allowable Charge between the Member and the Group Health Plan. After the Member's Benefit Year Deductible requirement is met, the Group Health Plan will pay the percentage of Allowable Charges as set forth on the Schedule of Benefits. The Member is responsible for the remaining percentage of the Allowable Charge. Coinsurance is calculated after any applicable Benefit Year Deductible or Copayment is subtracted from the Allowable Charge based upon the network charge or the lesser charge of the Provider.

Companion Benefit Alternatives (CBA): a separate company that is responsible for managing Behavioral Healthcare Services (including Preauthorization) on behalf of BCBSF.

Concurrent Care: an ongoing course of treatment to be provided over a period of time or number of treatments.

Congenital Disorder/Congenital Disease: a condition documented as existing at birth regardless of cause.

Continued Stay Review: the review that must be obtained by a Member (or the Member's Authorized Representative) regarding an extension of an Admission to determine if an Admission for longer than the time that was originally Preauthorized is Medically Necessary (when required). The Continued Stay Review process is outlined in Article II.

Copayment: the amount, if any, specified on the Schedule of Benefits that the Member must pay directly to the Provider each time the Member receives Benefits.

Corporation: Blue Cross and Blue Shield of Florida, Inc. (BCBSF).

Covered Expenses: the amount payable by the Group Health Plan for Benefits. The amount of Covered Expenses payable for Benefits is determined as set forth in this Plan of Benefits and at the percentages set forth on the Schedule of Benefits. Covered Expenses are subject to the limitations and requirements set forth in the Plan of Benefits and on the Schedule of Benefits. Covered Expenses will not exceed the Allowable Charge.

Custodial Care: non-skilled services that are primarily for the purpose of assisting an individual with daily living activities or personal needs (e.g., bathing, dressing and/or eating), which is not specific therapy for any illness or injury.

Durable Medical Equipment (DME): medical equipment that:

1. Can withstand repeated use;
2. Is Medically Necessary;
3. Is customarily used for the treatment of a Member's illness, injury, disease or disorder;
4. Is appropriate for use in the home;
5. Is not useful to a Member in the absence of illness or injury;
6. Does not include appliances that are provided solely for the Member's comfort or convenience;
7. Is a standard, non-luxury item; and,
8. Is ordered by a licensed medical doctor, oral surgeon, podiatrist or osteopath.

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment.

Emergency Admission Review: the review that must be obtained by a Member (or the Member's Authorized Representative) within twenty-four (24) hours of or by the end of the first working day after the commencement of an Admission to a Hospital to treat an Emergency Medical Condition. The Emergency Admission Review process is outlined in Article II.

Emergency Medical Condition: a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the Member, or with respect to a pregnant Member, the health of the Member or her unborn child, in serious jeopardy;

2. Serious impairment to bodily functions; or,

3. Serious dysfunction of any bodily organ or part.

Emergency Services: services, supplies and treatment for stabilization, evaluation and/or initial treatment of an Emergency Medical Condition when provided on an outpatient basis at a Hospital emergency room or department.

Employee: any employee of the Employer who is eligible for coverage and who is so designated to the Corporation by the Employer.

Employer: the entity providing this Plan of Benefits.

Employer's Effective Date: the date the Corporation begins to provide Services under this Agreement.

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

Group Health Plan: the employee welfare benefit plan established, administered and/or sponsored by the Employer to provide health Benefits to Employees and/or their dependents, directly or through insurance, reimbursement or otherwise.

HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Agency: an agency or organization licensed by the appropriate state regulatory agency to provide Home Health Care.

Home Health Care: part-time or intermittent nursing care; health aide services; or physical, occupational or speech therapy provided or supervised by a Home Health Agency and provided to a home-bound Member in such Member's private residence.

Hospice Care: care for terminally ill patients under the supervision of a licensed medical doctor and provided by an agency that is licensed or certified as a hospice or hospice care agency by the appropriate state regulatory agency.

Hospital: a short-term, acute care facility licensed as a hospital by the state in which it operates. A Hospital is primarily engaged in providing medical, surgical or acute behavioral health diagnosis and treatment of injured or sick persons by or under the supervision of a staff of licensed Providers and continuous twenty-four (24) hour-a-day services by licensed, registered, graduate nurses physically present and on duty. The term Hospital does not include Long Term Acute Care Hospitals; chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Hospital. A Hospital may participate in a teaching program. This means medical students, interns or residents participating in a teaching program may treat Members.

Identification Card: the card issued by the Corporation to a Member that contains the Member's identification number.

Incapacitated Dependent: a child who is:

1. Incapable of financial self-sufficiency by reason of total disability; and,

2. Dependent upon the Employee for at least fifty-one (51) percent of his or her support and maintenance.

A child must meet both of these requirements to qualify as an Incapacitated Dependent. The Employee will provide proof upon request. A child who is not incapacitated by the maximum dependent child age will not be covered.

Investigational or Experimental: surgical or medical procedures, supplies, devices or drugs which, at the time provided or sought to be provided, are, in the judgment of the Corporation, not recognized as conforming to generally accepted medical or behavioral health practice in the United States, or the procedure, drug or device:

1. Has not received required final approval in the United States to market from appropriate government bodies;

2. Is one about which the peer-reviewed medical literature in the United States does not permit conclusions concerning its effect on health outcomes;

3. Is not demonstrated in the United States to be superior to established alternatives;

4. Has not been demonstrated in the United States to improve net health outcomes; or,

5. Is one in which the improvement claimed is not demonstrated in the United States to be obtainable outside the Investigational or Experimental setting.

Legal Intoxication/Legally Intoxicated: the Member's blood alcohol level was at or in excess of the amount established under applicable state law to create a presumption and/or inference that the Member was under the influence of alcohol when measured by law enforcement or medical personnel.

Long-Term Acute Care Hospital: a long-term, acute care facility licensed as a long term care Hospital by the state in which it operates and which meets the other requirements of this definition. A Long-Term Acute Care Hospital provides highly skilled nursing, therapy and medical treatment to Members (typically over an extended period of time) although such Members may no longer need general acute care typically provided in a Hospital. A Long-Term Acute Care Hospital is primarily engaged in providing diagnostic services and medical treatment to Members with chronic diseases or complex medical conditions. The term Long-Term Acute Care Hospital does not include chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a long-term acute care hospital. A Long-Term Acute Care Hospital may participate in a teaching program. This means medical students, interns or residents participating in a teaching program may treat Members.

Maximum Payment: the maximum amount the Group Health Plan will pay (as determined by the Corporation) for a particular Benefit. The Maximum Payment will not be affected by any credit. The Maximum Payment will be one of the following as determined by the Corporation in its discretion:

1. The actual charge submitted to the Corporation for the service, procedure, supply or equipment by a Provider;

2. An amount based upon the reimbursement rates established by the Plan Sponsor in its Benefits Checklist;

3. An amount that has been agreed upon in writing by a Provider and the Corporation or a licensee of the BCBSA;

4. An amount established by the Corporation, based upon factors including, but not limited to:

    a. Governmental reimbursement rates applicable to the service, procedure, supply or equipment; or,

    b. Reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved; geographic location and circumstances giving rise to the need for the service, procedure, supply or equipment; or,

5. The lowest amount of reimbursement the Corporation allows for the same or similar service, procedure, supply or equipment when provided by a Participating Provider.

In addition, the Maximum Payment for Emergency Services by a Non-Participating Provider will be the greatest of the following:

1. The amount negotiated with Participating Providers for the particular Emergency Services (reduced by any in-network Copayment or Coinsurance);

2. The amount for Emergency Services calculated using same method the Corporation uses for out-of-network services, but substituting the relevant in-network Copayment or Coinsurance for the out-of-network Copayment or Coinsurance requirements; or,

3. The amount for Emergency Services that would be paid under Medicare, reduced by any in-network Copayment or Coinsurance for the services.

Medical Child Support Order: any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency which:

1. Provides child support with respect to a child or provides for health benefit coverage to a child, is made pursuant to a state domestic relations law (including a community property law) and relates to the Plan of Benefits; or,

2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.

A Medical Child Support Order must clearly specify:

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

2. A reasonable description of the type of coverage to be provided by the Group Health Plan to each such Alternate Recipient or the manner in which such type of coverage is to be determined;

3. The period to which such order applies; and,

4. Each Group Health Plan to which such order applies.

If the Medical Child Support Order is a national medical support notice, the order must also include:

1. The name of the issuing agency;

2. The name and mailing address of an official or agency that has been substituted for the mailing address of any Alternate Recipient; and,

3. The identification of the underlying medical child support order.

A Medical Child Support Order meets the requirement of this definition only if such order does not require a Group Health Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993).

Medical Supplies: supplies that are:

1. Medically Necessary;

2. Prescribed by a Provider acting within the scope of his or her license;

3. Are not available on an over-the-counter basis (unless such supplies are provided to a Member in a Provider's office and should not be included as part of the treatment received by the Member); and,

4. Are not prescribed in connection with any treatment or Benefit that is excluded under this Plan of Benefits.

Medically Necessary/Medical Necessity: using United States standards health care services and/or Behavioral Health Services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical or behavioral health practice;

2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;

3. Not primarily for the convenience of the patient, patient's caregiver(s) or Provider; and,

4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

All requirements of the above-referenced definition must be met in order for a health care service or Behavioral Health Service to be deemed Medically Necessary. The failure of a health care service or Behavioral Health Service to meet any one of the above referenced requirements means, in the discretion of the Corporation or CBA, the health care service or Behavioral Health Service does not meet the definition of Medically Necessary.

For the purposes of determining Medical Necessity:

1. The Corporation and CBA have the discretion to utilize and rely upon any medical and behavioral health (which includes substance use and mental health) standards, policies, guidelines, criteria, protocols, manuals, publications, studies or literature (herein collectively referred to as "criteria"), whether developed by them or others, which, in their discretion, are determined to be generally accepted standards by the medical and/or behavioral health community;

2. "Generally accepted standards of medical or behavioral health practice" means United States standards that are based on credible scientific evidence published in peer-reviewed medical and/or behavioral health literature generally recognized by the relevant United States medical or behavioral health community, physician or behavioral health specialty society recommendations, and/or any other factors deemed relevant in the discretion of the Corporation or CBA; and,

3. The Corporation and CBA may, in their discretion, use the following materials, including but not limited to, Corporate Administrative Medical ("CAM") Policies, Technology Evaluation Center ("TEC") Assessments, Behavioral Health Care Utilization Management Criteria and/or any Care Guidelines or criteria by MCG Health, LLC, its affiliated companies, or other entities generally recognized as providing industry guidance and expertise, which reflect clinically appropriate health care services and Behavioral Health Services and generally accepted standards of medical and behavioral health practice. MCG Health, LLC, its affiliated companies, and/or other entities are independent companies that develop evidence based guidelines and criteria for medical, behavioral health and insurance industries to interpret clinical determinations and determine the Medical Necessity and appropriateness of requested services, procedures, devices and supplies.

Member: an Employee or dependent who has enrolled under the Group Health Plan.

Mental Health Services: treatment (except Substance Use Disorder Services) that is defined, described or classified as a psychiatric disorder or condition in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and which is not otherwise excluded by the terms and conditions of this Plan of Benefits.

Natural Teeth: teeth that:

1. Are free of active or chronic clinical decay;

2. Have at least fifty percent (50%) bony support;

3. Are functional in the arch; and,

4. Have not been excessively weakened by multiple dental procedures; or,

5. Teeth that have been treated for one (1) or more of the conditions referenced in 1-4 above and, as a result of such treatment, have been restored to normal function.

Non-Participating Provider: any Provider who does not have a current, valid Provider Agreement.

Orthopedic Device: any ridged or semi-ridged leg, arm, back or neck brace and casting materials that are directly used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

Orthotic Device: any device used to mechanically assist, restrict or control function of a moving part of the Member's body.

Out-of-Pocket Maximum: the maximum amount (listed on the Schedule of Benefits) incurred during a Benefit Year that a Member will be required to pay.

Over-the-Counter Drug: a drug that does not require a prescription.

Participating Provider: a Provider who has a current, valid Provider Agreement.

Plan: any program that provides Benefits or services for medical or dental care or treatment, including:

1. Individual or group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage; and,

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

Each contract or other arrangement for coverage is a separate Plan for purposes of this Plan of Benefits. If a Plan has two (2) or more parts and the coordination of benefit rules in Article IV apply only to one (1) of the parts, each part is considered a separate Plan.

Plan Administrator: the entity charged with the administration of the Group Health Plan. The Employer is the Plan Administrator of the Group Health Plan.

Plan of Benefits: this document which reflects the Benefits offered under the Group Health Plan based on the Benefits Checklist. The Plan of Benefits includes the Schedule of Benefits. Employer agrees that the Plan of Benefits will, at a minimum, be incorporated as a part of the Group Health Plan.

Plan of Benefits Effective Date: 12:01 a.m. EST on the date listed on the Schedule of Benefits.

Plan Sponsor: the party sponsoring the Group Health Plan. The Employer is the Plan Sponsor of the Group Health Plan.

Post-Service Claim: any claim for a Benefit that is not a Pre-Service Claim.

Preadmission Review: the review that must be obtained by a Member (or the Member's Authorized Representative) prior to all Admissions that are not related to an Emergency Medical Condition. The Preadmission Review process is outlined in Article II.

Preauthorized/Preauthorization: the approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member. The Preauthorization process is outlined in Article II.

Prescription Drug: a drug or medicine that is:

1. Required to be labeled that it has been approved by the FDA; and,

2. Bears the legend "Caution: Federal Law prohibits dispensing without a prescription" prior to being dispensed or delivered, or labeled in a similar manner.

Additionally, to qualify as a Prescription Drug, the drug must be prescribed by a licensed Provider acting within the scope of his or her license.

Certain Over-the-Counter Drugs may be designated as Prescription Drugs, at the discretion of the Corporation. Such designated Over-the-Counter Drugs will be listed on the PDL.

Prescription Drug List (PDL)/Formulary: a listing of drugs approved for a specified level of Benefits by the Corporation under the Plan of Benefits. This list shall be developed and subject to periodic review and modification by the Corporation. The most up-to-date version of the PDL is available on the Corporation's website.

Prescription Drug Preauthorization Program: programs that prohibit patients from obtaining medications until approvals have been obtained.

Pre-Service Claim: any request for a Benefit where Preauthorization must be obtained before receiving the medical care, service or supply.

Primary Plan: a Plan whose Benefits must be determined without taking into consideration the existence of another Plan.

Private Duty Nursing (PDN): hourly or shift skilled nursing care provided in a patient's home. PDN provides more individual and continuous skilled care than can be provided in a skilled nurse visit through a Home Health Agency. The intent of PDN is to assist the patient with complex direct skilled nursing care, to develop caregiver competencies through training and education and to optimize patient health status and outcomes. The frequency and duration of PDN services is intermittent and temporary in nature and is not intended to be provided on a permanent ongoing basis. PDN is not long-term care.

Prosthetic Device: any device that replaces all or part of a missing body organ or body member, except a wig, hairpiece or any other artificial substitute for scalp hair.

Protected Health Information (PHI): has the same meaning as the term is defined under HIPAA.

Provider: any person or entity licensed by the appropriate state regulatory agency and legally entitled to practice within the scope of such person or entity's license in the practice of any of the following:

1. Medicine;

2. Dentistry;

3. Optometry;

4. Podiatry;

5. Chiropractic services;

6. Behavioral health;

7. Physical therapy;

8. Oral surgery;

9. Speech therapy;

10. Occupational therapy; or,

11. Osteopathy.

The term Provider also includes a Hospital; a Rehabilitation Facility; a Skilled Nursing Facility; a physician assistant; nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a licensed medical doctor or oral surgeon; and Behavioral Health Services when performed by a Behavioral Health Provider, licensed professional counselor, masters level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Provider approved by the Corporation. The term Provider does not include interns, residents, physical trainers, lay midwives or masseuses.

Provider Agreement: an agreement between the Corporation (or another BCBSA licensee) and a Provider under which the Provider has agreed to accept the Corporation's allowance (as set forth in the Provider Agreement) as payment in full for Benefits (subject to the member liability amounts) and other mutually acceptable terms and conditions.

Provider Services: includes the following services:

A. When performed by a Provider or a Behavioral Health Provider within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards:

   1. Office visits, which are for the purpose of seeking or receiving care for a preventive service, illness or injury;

   2. Basic diagnostic services and machine tests; or,

   3. Behavioral Health Services.

B. When performed by a licensed medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, dentist, physical therapist, speech therapist, occupational therapist or licensed psychologist with a doctoral degree:

   1. Benefits rendered to a Member in a Hospital or Skilled Nursing Facility;

   2. Benefits rendered in a Member's home;

   3. Surgical Services;

   4. Anesthesia services, including the administration of general or spinal block anesthesia;

   5. Radiological examinations;

6. Laboratory tests; and,

7. Maternity services, including consultation; prenatal care; conditions directly related to pregnancy, delivery and postpartum care and delivery of one (1) or more infants. Provider Services also include maternity services performed by certified nurse midwives when supervised by a licensed medical doctor.

Qualified Medical Child Support Order: a Medical Child Support Order that:

1. Creates or recognizes the existence of an Alternate Recipient's right to enroll under this Plan of Benefits; or,

2. Assigns to an Alternate Recipient the right to enroll under this Plan of Benefits.

Qualifying Event: for continuation of coverage purposes under Article V, a Qualifying Event is any one of the following:

1. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked;

2. Death of the Employee;

3. Divorce or legal separation of the Employee from his or her spouse;

4. A child ceasing to qualify as a dependent under this Plan of Benefits;

5. Entitlement to Medicare by an Employee or by a parent of a child; or,

6. A proceeding in bankruptcy under Title 11 of the United States Code with respect to an Employer from whose employment an Employee retired at any time.

Rehabilitation Facility: licensed facility operated for the purpose of assisting Members with neurological or other physical injuries to recover as much restoration of function as possible.

Residential Treatment Center (RTC): a licensed institution, other than a Hospital, which meets all six (6) of these requirements:

1. Maintains permanent and full-time facilities for bed care of resident patients;

2. Has the services of a psychiatrist (addictionologist, when applicable) or physician extender available at all times and is responsible for the diagnostic evaluation and provides face-to-face evaluation services with documentation a minimum of once/week and as needed as indicated;

3. Has a registered nurse (RN) present onsite who is in charge of patient care along with one (1) or more RNs or licensed practical nurses (LPNs) onsite at all times twenty-four (24) hours per day and seven (7) days per week;

4. Keeps a daily medical record for each patient;

5. Is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp or any other facility that provides Custodial Care; and,

6. Is operating lawfully as a residential treatment center in the area where it is located.

Schedule of Benefits: the pages of this Plan of Benefits, so titled, which specify the coverage provided and the applicable Copayments, Coinsurance, Benefit Year Deductibles and Benefit limitations.

Second Surgical Opinion: the medical opinion of a board-certified surgeon regarding an elective surgical procedure. The opinion must be based on the surgeon's examination of the patient. The examination must be performed after another licensed medical doctor has proposed to perform surgery, but before the surgery is performed. The second licensed medical doctor must not be associated with the primary licensed medical doctor.

Secondary Plan: a Plan that is not a Primary Plan. When this Plan of Benefits constitutes a Secondary Plan, availability of Benefits are determined after those of the other Plan and may be reduced because of benefits payable under the other Plan.

Skilled Nursing Facility: an institution other than a Hospital that is certified and licensed by the appropriate state regulatory agency as a skilled nursing facility.

Special Care Unit: a specially equipped unit of a Hospital, set aside as a distinct care area, staffed and equipped to handle seriously ill Members requiring extraordinary care on a concentrated and continuous basis such as burn, intensive or coronary care units.

Specialist: a licensed medical doctor who specializes in a particular branch of medicine.

Specialty Drugs: Prescription Drugs, as identified by the Corporation, that treat a complex clinical condition and/or require special handling, such as refrigeration. They generally require complex clinical monitoring, training and expertise. Specialty Drugs include, but are not limited to, infusible Specialty Drugs for chronic diseases, injectable and self-injectable drugs for acute and chronic diseases and specialty oral drugs. Specialty Drugs are used to treat acute and chronic disease states (e.g., growth deficiencies, hemophilia, Multiple Sclerosis, Rheumatoid Arthritis, Gaucher's Disease, Hepatitis, cancer, organ transplantation, Alpha 1-Antitrypsin Disease and immune deficiencies).

Substance Use Disorder: the continued use of, abuse of and/or dependence on legal or illegal substance(s), despite significant consequences or marked problems associated with the use (as defined, described or classified in the most current version of *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association).

Substance Use Disorder Services: services or treatment relating to Substance Use Disorder.

Surgical Services: an operative or cutting procedure, including the usual, necessary and related pre-operative and post-operative care when performed by a licensed medical doctor.

Telehealth: the exchange of Member information during which Members can have a telephone or video consultation with a licensed health care professional.

Telemedicine: the exchange of Member information from one eligible referring licensed Provider (for purposes of Telemedicine outlined herein, the "Referring Provider") site to another eligible consulting licensed Provider (for purposes of Telemedicine outlined herein, the "Consulting Provider") site for the purpose of providing medical care to a Member in circumstances in which in person, face-to-face contact with the Consulting Provider is not necessary. The exchange must occur via two-way, real-time, interactive, HIPAA-compliant, electronic audio and video telecommunications systems.

Urgent Care Claim: any claim for medical care or treatment where making a determination under other than normal time frames could seriously jeopardize the Member's life or health or the Member's ability to regain maximum function, or, in the opinion of a licensed medical doctor or oral surgeon with knowledge of the Member's medical condition, would subject the Member to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

USERRA: the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Well Baby Care/Well Child Care: care for dependents. Benefits are payable as specified on the Schedule of Benefits.

ARTICLE II - BENEFITS

A. PAYMENT

The payment for Benefits is subject to all terms and conditions of this Plan of Benefits. In the event of a conflict between the Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Oral statements cannot alter the terms of the Plan of Benefits or Schedule of Benefits. The Group Health Plan will only pay for Benefits:

1. Performed or provided on or after the Member effective date;
2. Performed or provided prior to termination of coverage;
3. Provided by a Provider within the scope of his or her license;
4. For which the required Preadmission Review, Emergency Admission Review, Preauthorization and/or Continued Stay Review has been requested and Preauthorization was received from the Corporation;
5. That are Medically Necessary;
6. That are not subject to an exclusion under Article III of this Plan of Benefits;
7. After the payment of all required Benefit Year Deductibles, Coinsurance and Copayments; and,
8. That comply with the Corporations corporate medical policy unless otherwise indicated in the Benefits Checklist.

The amount payable for Benefits is determined as set forth in this Plan of Benefits and on the Schedule of Benefits. Benefits are subject to the limitations and requirements set forth in this Plan of Benefits and on the Schedule of Benefits. Payment for Benefits will not exceed the Allowable Charge.

B. PREAUTHORIZATION

All Admissions and some Benefits require Preauthorization to determine the Medical Necessity. The Group Health Plan reserves the right to add or remove Benefits that are subject to Preauthorization. If Preauthorization is not obtained, Benefits may be reduced. Specific penalties are listed on the Schedule of Benefits. Preauthorization is obtained through the following procedures:

1. For all Admissions that are not the result of an Emergency Medical Condition, Preauthorization is granted or denied in the course of the Preadmission Review;

2. For all Admissions that result from an Emergency Medical Condition, Preauthorization is granted or denied in the course of the Emergency Admission Review;

3. For Admissions that are anticipated to require more days than approved through the initial review process, Preauthorization for additional days is granted or denied in the course of the Continued Stay Review;

4. For specific Benefits that require Preauthorization, Preauthorization is granted or denied in the course of the Preauthorization process; and,

5. For items requiring Preauthorization, the Corporation must be called at the numbers given on the Identification Card.

Preauthorization means only that the Corporation has determined that the Benefit is Medically Necessary. Preauthorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Member. Notwithstanding Preauthorization, payment for Benefits is subject to a Member's eligibility and all other limitations and exclusions contained in this Plan of Benefits. A Member's entitlement to Benefits is not determined until the Member's claim is processed.

C. SPECIFIC COVERED BENEFITS

If all of the following requirements are met, the Group Health Plan will pay for the Benefits described in Article II:

1. All of the requirements of Article II must be met;

2. The Benefit must be listed in Article II;

3. The Benefit must not have a "**Non-Covered**" notation associated with it on the Schedule of Benefits;

4. The Benefit (separately or collectively) must not exceed the dollar or other limitations contained on the Schedule of Benefits; and,

5. The Benefit must not be subject to one (1) or more of the exclusions set forth in Article III.

D. BENEFITS

ABA RELATED TO AUTISM SPECTRUM DISORDER

Benefits will be paid for ABA related to Autism Spectrum Disorder as set forth on the Schedule of Benefits. Services must be provided by or under direction of an approved Participating Provider.

ACUPUNCTURE

Benefits will be paid for acupuncture treatment or services as set forth on the Schedule of Benefits.

ALLERGY SERUM

Benefits will be paid for allergy serum as set forth on the Schedule of Benefits.

AMBULANCE SERVICES

Benefits will be paid for professional ground and air ambulance services to the nearest network Hospital in case of an accident or Emergency Medical Condition. The following requirements apply to all ground and air ambulance services and transports:

1. The transport is Medically Necessary and reasonable under the circumstances;

2. A Member is transported;

3. The destination is local within the United States; and,

4. The facility is medically appropriate to treat the Member's condition.

Benefits will be paid for ground ambulance transport between two Hospitals only when such ground ambulance transport has been Preauthorized and the Corporation confirms that the receiving Hospital is the closest facility that can provide medically appropriate care to treat the Member's condition. Transport from one facility to a new facility for the purpose of the Member obtaining a lower level of care at the new receiving facility must be Preauthorized. Repatriation for Member convenience is excluded and is not a Benefit for which Covered Expenses are payable.

Preauthorization is required for transportation as an inpatient from one Hospital to a second Hospital using an air ambulance. The following requirements must be met:

1. The first Hospital does not have the needed Hospital or skilled nursing care to treat the Member's illness or injury (such as burn care, cardiac care, trauma care, and critical care);

2. The second Hospital is the nearest medically appropriate facility to treat the Member's illness or injury;

3. A ground ambulance transport would endanger the Member's medical condition; and,

4. The transport is not related to a hospitalization outside the United States.

CARDIAC REHABILITATION

Benefits will be paid for cardiac rehabilitation as set forth on the Schedule of Benefits.

CHIROPRACTIC SERVICES

Benefits will be paid for services and Medical Supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. Benefits shall include but not be limited to:

1. Spinal manipulation/subluxation;

2. Modalities;

3. Office visits;

4. Unattended electrical stimulation, including Transcutaneous Electrical Nerve Stimulation (TENS) units when performed in the office.

CLEFT LIP OR PALATE

Benefits will be paid for care and treatment of a congenital cleft lip or palate, or both, and any physical condition or illness that is related to or developed as a result of a cleft lip or palate.

Benefits shall include but not be limited to:

1. Oral and facial Surgical Services, surgical management and follow-up care;
2. Prosthetic Device treatment, such as obturators, speech appliances and feeding appliances;
3. Orthodontic treatment and management;
4. Prosthodontia treatment and management;
5. Otolaryngology treatment and management;
6. Audiological assessment, treatment and management, including surgically implanted amplification devices; and,
7. Physical therapy assessment and treatment.

If a Member with a cleft lip or palate is covered by a dental policy, then teeth capping, prosthodontics and orthodontics shall be covered by the dental policy to the limit of coverage provided under such dental policy prior to coverage under this Group Health Plan. Excess medical expenses (after coverage under any dental policy is exhausted) shall be provided as for any other condition or illness under the terms and conditions of this Group Health Plan.

CLINICAL TRIALS

Benefits will be paid for routine Member costs for items and services related to Clinical Trials when:

1. The Member has cancer or other life-threatening disease or condition; and,
2. Either:
    a. the referring Provider is a Participating Provider that has concluded that the Member's participation in such trial would be appropriate; or,
    b. the Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate; and,
3. The services are furnished in connection with an approved Clinical Trial.

COCHLEAR IMPLANTS

Benefits will be paid for unilateral or bilateral cochlear implantation of a U.S. Food and Drug Administration approved cochlear implant as set forth on the Schedule of Benefits.

COGNITIVE THERAPY

Benefits will be paid for cognitive therapy as set forth on the Schedule of Benefits.

DENTAL CARE FOR ACCIDENTAL INJURY

Benefits will be paid for dental services to Natural Teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force, such as a car accident or a blow by a moving object. No Benefits will be paid for injuries that occur while the Member is in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require Preauthorization; however, the dentist must submit a plan for any future treatment to the Corporation for review and Preauthorization before such treatment is rendered if Benefits are to be paid. Benefits are limited to treatment for only six (6) months from the date of the accidental injury.

DIABETES EDUCATION

Benefits will be paid for outpatient self-management training and education for Members with diabetes mellitus provided that such training and educational Benefits are rendered by a Provider whose program is recognized by the American Diabetes Association.

DURABLE MEDICAL EQUIPMENT

Benefits will be paid for Durable Medical Equipment. The Group Health Plan will decide whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Group Health Plan will not pay Benefits for Durable Medical Equipment that is solely used by a Member in a Hospital or that the Group Health Plan determines is included in any Hospital room charge.

EMERGENCY SERVICES

Benefits will be paid for the treatment of Emergency Medical Conditions. Benefits are only available to treat an Emergency Medical Condition provided on an outpatient basis at a Hospital emergency room or department and only for as long as the condition continues to be considered an Emergency Medical Condition.

GENDER DYSPHORIA

Benefits will be paid for Medical Supplies, services or charges related to the diagnosis or treatment of gender dysphoria as outlined in the Corporation's medical policy.

GENETIC COUNSELING

Benefits will be paid for genetic counseling as set forth on the Schedule of Benefits.

GYNECOLOGICAL EXAMINATION

Benefits will be paid for routine gynecological examinations each Benefit Year for female Members.

HABILITATION

Benefits will be paid for habilitation, including assisting a child with achieving developmental skills when impairments have caused delaying or blocking of initial acquisition of the skills. Habilitation can include fine motor, gross motor or other skills that contribute to mobility communication and performance of activities of daily living. The services will be described in an individual's plan of care.

HEARING AIDS AND EXAMS

Benefits will be paid for hearing aids and examinations for the prescription or fitting of hearing aids as set forth on the Schedule of Benefits.

HOME HEALTH CARE

Benefits will be paid for Home Health Care when rendered to a homebound Member in the Member's current place of residence.

HOSPICE CARE

Benefits will be paid for Hospice Care.

HOSPITAL SERVICES

Benefits will be paid for Admissions as follows:

1. Semiprivate room, board and general nursing care;

2. Private room, at semiprivate rate;

3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit rather than in another portion of the Hospital;

4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;

5. Diagnostic services, including interpretation of radiological and laboratory examinations, electrocardiograms and electroencephalograms; and,

6. In a Long-Term Acute Care Hospital.

Benefits for Admissions may be subject to the requirements for Preadmission Review, Emergency Admission Review and Continued Stay Review.

The day on which a Member leaves a Hospital, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Member returns to the Hospital by midnight of the same day. The day a Member enters a Hospital is treated as a day of Admission. The days during which a Member is not physically present for inpatient care are not counted as Admission days.

HUMAN ORGAN AND TISSUE TRANSPLANTS

1. Benefits will be paid for certain human organ and tissue transplants. To be covered, such transplants must be provided from a human donor to a Member and provided at a transplant center approved by the Group Health Plan. Benefits shall only be paid for the human organ and tissue transplants as set forth on the Schedule of Benefits.

2. The payment of Benefits for living donor transplants will be subject to the following conditions:

    a. When both the transplant recipient and the donor are Members, Benefits will be paid for both.

    b. When the transplant recipient is a Member and the donor is not, Benefits will be paid for both the recipient and the donor to the extent that the donor does not have health benefits provided by any other source.

    c. When the donor is a Member and the transplant recipient is not, no Benefits will be paid for either the donor or the recipient.

3. Human organ and tissue transplant coverage includes expenses incurred for legal donor organ and tissue procurement and all inpatient and outpatient Hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy and air ambulance expenses.

IN-HOSPITAL MEDICAL SERVICE

Benefits will be paid for a licensed medical doctor or Behavioral Health Provider's visits to a Member during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or obstetrical service is required as follows:

1. In-Hospital medical Benefits primarily for Mental Health Services and Substance Use Disorder Services;

2. In-Hospital medical Benefits in a Skilled Nursing Facility will be provided for visits of a Provider, limited to one (1) visit per day, not to exceed the number of visits if set forth on the Schedule of Benefits;

3. Where two (2) or more Providers of the same general specialty render in-Hospital medical visits on the same day, payment for such services will be made only to one (1) Provider;

4. Concurrent medical and surgical Benefits for in-Hospital medical services are only provided:

    a. When the condition for which in-Hospital medical services requires medical care not related to Surgical Services or obstetrical service and does not constitute a part of the usual, necessary and related pre-operative or post-operative care but requires supplemental skills not possessed by the attending surgeon or his or her assistant; and,

    b. When the surgical procedure performed is designated by the Group Health Plan as a warranted diagnostic procedure or as a minor surgical procedure.

5. When the same Provider renders different levels of care on the same day, Benefits will only be provided for the highest level of care.

INFERTILITY

Benefits will be paid for the diagnosis of and testing for infertility and treatment of the underlying condition causing infertility.

MAMMOGRAPHY TESTING

Benefits will be paid for mammography testing. Benefits will be paid for additional mammograms during a Benefit Year based on Medical Necessity.

MEDICAL SUPPLIES

Benefits will be paid for Medical Supplies, provided that the Group Health Plan will not pay Benefits separately for Medical Supplies that are or should be provided as part of another Benefit.

MENTAL HEALTH SERVICES

Benefits will be paid for Mental Health Services provided on an inpatient or outpatient basis.

NUTRITIONAL COUNSELING

Benefits will be paid for nutritional counseling, including services by registered Dieticians.

OBESITY RELATED PROCEDURES

Benefits will be paid for the following if set forth on the Schedule of Benefits:

Services, supplies, treatment or medication for the management of morbid obesity, obesity, weight reduction, weight control or dietary control (collectively referred to as "obesity-related treatment") including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures or gastric restrictive procedures. Also included are services, supplies or charges for the treatment or correction of complications from obesity-related treatment. Services, supplies or charges for the reversal of obesity-related treatments and reconstructive procedures necessitated by weight loss are covered.

OBSTETRICAL SERVICES

Benefits will be paid for obstetrical services. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.

Under the terms of the Newborn and Mother's Health Act of 1996, the Group Health Plan generally may not 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 (not including the day of delivery) or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the Group Health Plan may not require that a Provider obtain authorization from the Corporation for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. However, Preauthorization is required to use certain Providers or facilities or to reduce out-of-pocket costs.

ORTHOGNATHIC SURGERY

Benefits will be paid for any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication or orthognathic deformities for which the resulting disorder is breathing, nutritional or speech related. Services exclude dental conditions related to biting, chewing or teeth.

ORTHOPEDIC DEVICES

Benefits will be paid for Orthopedic Devices.

ORTHOTIC DEVICES

Benefits will be paid for Orthotic Devices that are not available on an over-the-counter basis and are not otherwise excluded under this Plan of Benefits.

OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES

Benefits will be paid for Surgical Services and diagnostic services including radiological examinations, laboratory tests and machine tests, performed in an outpatient Hospital setting or an Ambulatory Surgical Center.

OUTPATIENT REHABILITATION SERVICES

Benefits will be paid, subject to the following paragraph, for physical therapy, occupational therapy and rehabilitation services as set forth on the Schedule of Benefits.

Benefits for outpatient rehabilitation services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.

OXYGEN

Benefits will be paid for oxygen. Durable Medical Equipment for oxygen use in a Member's home is covered under the Durable Medical Equipment Benefit.

PAP SMEAR

Benefits will be paid for a Pap smear as part of a gynecological examination regardless of Medical Necessity. Benefits will be paid for additional Pap smears during a Benefit Year based on Medical Necessity.

PHYSICAL EXAMINATION

Benefits will be paid for physical examinations for Members.

PREVENTIVE SERVICES

Benefits will be paid for preventive health services required under the ACA as follows:

1. Evidence based services that have a rating of A or B in the current United States Preventive Services Task Force (USPSTF) recommendations;

2. Immunizations as recommended by the CDC; and,

3. Preventive care and screenings for children and women as recommended by the Health Resources and Services Administration (HRSA).

These Benefits are paid without any cost-sharing by the Member when the services are provided by a Participating Provider. Any other covered preventive screenings will be provided as set forth on the Schedule of Benefits.

PRIVATE DUTY NURSING

Benefits will be paid for Private Duty Nursing outside of Home Health Care or a Hospital setting.

PROSTATE EXAMINATION

Benefits will be paid for prostate examinations per Benefit Year regardless of Medical Necessity as set forth on the Schedule of Benefits. Benefits will be paid for additional prostate examinations during a Benefit Year based on Medical Necessity.

PROSTHETIC DEVICES

Benefits will be paid for a Prosthetic Device, other than a dental or cranial prosthetic, which is a replacement for a body part and which meets minimum specifications for the body part it is replacing regardless of the functional activity level. Coverage is provided for the cost of the standard, non-luxury item only. Components that are considered deluxe or upgraded over a standard model are not a covered service. Except as provided below, Benefits are provided for only the initial temporary prosthesis and one (1) permanent prosthesis. No Benefits are provided for repair, replacement or duplicates, nor are Benefits provided for services related to the repair or replacement of such prosthetics except when necessary due to a change in the Member's medical condition and with prior authorization from the Corporation.

Prosthetic Devices do not include bioelectric, microprocessor or computer programmed prosthetic components.

PROVIDER SERVICES

Benefits will be paid for Provider Services, provided that when different levels of Provider Services are provided on the same day, Benefits will only be paid for the highest level of Provider Services.

PULMONARY REHABILITATION

Benefits will be paid for pulmonary rehabilitation as set forth on the Schedule of Benefits.

RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

In the case of a Member who is receiving Benefits in connection with a mastectomy, Benefits will be paid for each of the following (if requested by such Member):

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; and,

3. Prosthetic Devices and physical complications at all stages of the mastectomy, including lymphedema.

REHABILITATION

Benefits will be paid, as specified on the Schedule of Benefits, for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment if the following criteria are met:

1. All such treatment must be ordered by a licensed medical doctor;

2. All such treatment may require Preauthorization and must be performed by a Provider and at a location designated by the Group Health Plan;

3. The documentation that accompanies a request for rehabilitation meets the criteria outlined in the Corporation's medical policy; and,

4. All such rehabilitation Benefits are subject to periodic review by the Group Health Plan.

After the initial rehabilitation period, continuation of rehabilitation Benefits will require documentation that the Member is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

RESIDENTIAL TREATMENT CENTERS

Benefits will be paid for Residential Treatment Centers as set forth on the Schedule of Benefits.

SKILLED NURSING FACILITY SERVICES

Benefits will be paid for Admissions in a Skilled Nursing Facility as follows:

1. Semiprivate room, board, and general nursing care;

2. Private room, at semiprivate rate;

3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit;

4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;

5. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; and,

6. In a Long-Term Acute Care Hospital.

Benefits for Admissions may be subject to the requirements for Preadmission Review, Emergency Admission Review, and Continued Stay Review.

The day on which a Member leaves a Skilled Nursing Facility, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Member returns to the Skilled Nursing Facility by midnight of the same day. The day a Member enters a Skilled Nursing Facility is treated as a day of Admission. The days during which a Member is not physically present for inpatient care are not counted as Admission days.

SPECIALTY DRUGS

Certain Specialty Drugs may be considered medical Benefits and may:

1. Require Preauthorization; and/or,

2. Be subject to certain place of service requirements.

For any Specialty Drugs paid as medical Benefits, the Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit maximum will apply as set forth on the Schedule of Benefits. A list of Specialty Drugs as well as information about any related requirements and/or restrictions may be obtained by contacting the Corporation at the number listed on the Identification Card or at www.MyHealthToolkitFL.com.

SPEECH THERAPY

Benefits will be paid for speech therapy as set forth on the Schedule of Benefits.

SUBSTANCE USE DISORDER SERVICES

Benefits will be paid for Substance Use Disorder Services as set forth on the Schedule of Benefits.

SURGICAL SERVICES

Benefits will be paid for Surgical Services performed by a licensed medical doctor or oral surgeon, as applicable, for treatment and diagnosis of disease or injury or for obstetrical services, as follows:

1. Surgical Services, subject to the following:

    a. If two (2) or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only.

    b. If two (2) or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure bearing the highest Allowable Charge plus one-half (1/2) of the Allowable Charge for all other operations or procedures performed.

    c. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, fifty percent (50%) for the procedure bearing the second and third highest Allowable Charges, twenty-five percent (25%) for the procedures bearing the fourth through the eighth highest Allowable Charges and ten percent (10%) for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge and fifty percent (50%) of the charge for each subsequent procedure.

    d. If an operation or procedure is performed in two (2) or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure.

    e. If two (2) or more licensed medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant surgeon or anesthesiologist, the Allowable Charge, subject to the above paragraphs, will be coverage for the services of only one (1) licensed medical doctor or oral surgeon (as applicable) or will be prorated between them by the Group Health Plan when so requested by the licensed medical doctor or oral surgeon in charge of the case.

    f. Certain surgical procedures are designated as separate procedures by the Group Health Plan. The Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowable Charge for the major procedure only.

2. Assistant Surgeon services that consists of the Medically Necessary service of one (1) licensed medical doctor, oral surgeon, physician assistant or nurse practitioner who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital and when such surgical assistant service is not available by an intern, resident or in-house physician. The Group Health Plan will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the licensed medical doctor's or oral surgeon's (as applicable) actual charge.

3. Anesthesia services that consists of services rendered by a licensed medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

SUSTAINED HEALTH BENEFITS

Benefits will be paid for certain routine annual Benefits (known as Sustained Health Benefits) as set forth on the Schedule of Benefits. These Benefits are designed to cover costs associated with routine care and are provided in addition to the Preventive Services covered under the ACA. Because these are additional Benefits, age and monetary limitations may be imposed and cost-sharing may be required by the Member.

TELEHEALTH

Benefits will be paid for Telehealth services which are initiated by either a Member or Provider and are provided by licensed health care professionals who have been credentialed as eligible Telehealth Providers.

TELEMEDICINE

Benefits will be paid for Telemedicine services as follows:

Office and outpatient visits that are conducted via Telemedicine are counted towards any applicable Benefit limits for these services.

Consulting and referring Providers must be Participating Providers who have been credentialed as eligible Telemedicine Providers.

Telemedicine services will be covered by the Group Health Plan under the following circumstances:

1. The medical care is individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the Member's need; and,

2. The medical care can be safely furnished, and there is no equally effective, more conservative and less costly treatment available.

Examples of interactions that are not reimbursable Telemedicine services and will not be reimbursed are:

1. Telephone conversations;

2. Email messages;

3. Facsimile transmissions; or,

4. Internet-based audio-video communication that is not secure and HIPAA-compliant (e.g., Skype).

TEMPOROMANDIBULAR JOINT (TMJ) DISORDER

Benefits will be paid for any service for the treatment of dysfunctions or derangements of the temporomandibular joint, including orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint.

VARICOSE VEIN AND VENOUS INSUFFICIENCY TREATMENT

Benefits will be paid for services, supplies or treatment for varicose veins and/or venous insufficiency, including but not limited to endovenous ablation, vein stripping or the injection of sclerosing solutions, as outlined in the Corporation's medical policy.

ARTICLE III - EXCLUSIONS AND LIMITATIONS

THE EMPLOYER'S GROUP HEALTH PLAN WILL NOT PAY ANY AMOUNT FOR THE SERVICES AND PRODUCTS LISTED IN THIS ARTICLE III EXCEPT: (1) SERVICES ARE RENDERED BY A HEALTH CARE PROVIDER AS PART OF A VALUE-BASED PROGRAM OR (2) IF REQUIRED BY LAW.

ACTS OF WAR

Illness contracted or injury sustained as a result of a Member's participation as a combatant in a declared or undeclared war, or any act of war, or while in military service.

ADMISSIONS THAT ARE NOT PREAUTHORIZED

If Preauthorization is not received, Benefits may be reduced (or denied) as set forth on the Schedule of Benefits.

AMBULANCE

Ambulance services:

1. That do not meet coverage guidelines outlined in the Ambulance Services description in Article II;

2. That are not Medically Necessary and reasonable;

3. For transport to a more distant Hospital solely for the Member's convenience, regardless of the reason, or to allow the Member to use the services of a specific Provider or Specialist. The Group Health Plan will pay the base rate and mileage for a Medically Necessary ambulance transport to the nearest medically appropriate facility. If the transport is to a facility that is not the nearest medically appropriate facility, the Member is responsible for additional cost incurred to go to the Member's preferred facility;

4. If the Member is medically stable and the situation does not involve an emergency, except as specified in Article II; or,

5. For transport from a Hospital in connection with a hospitalization outside the United States.

Any and all travel expenses including, but not limited to, transportation, lodging and repatriation are excluded.

AUTO ACCIDENTS

This Plan of Benefits does not provide coverage for claims paid or payable under an automobile insurance policy or any other type of liability insurance policy. Automobile insurance policies include, but are not limited to, no fault, personal injury protection, medical payments, liability, uninsured and underinsured policies, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.

BEHAVIORAL, EDUCATIONAL OR ALTERNATE THERAPY PROGRAMS

Any behavioral, educational or alternative therapy techniques to target cognition, behavior language and social skills modification, including:

1. Applied Behavioral Analysis (ABA) therapy unless Medically Necessary for the treatment of Autism Spectrum Disorder;
2. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
3. Higashi schools/daily life;
4. Facilitated communication;
5. Floor time;
6. Developmental Individual-Difference Relationship-based model (DIR);
7. Relationship Development Intervention (RDI);
8. Holding therapy;
9. Movement therapies;
10. Music therapy; and,
11. Animal assisted therapy.

BENEFITS PROVIDED BY STATE OR FEDERAL PROGRAMS

Any service or charge for a service to the extent that the Member is entitled to payment or benefits relating to such service under any state or federal program that provides healthcare benefits, including, but not limited to, Medicare, TRICARE and Medicaid, but only to the extent that benefits are paid or are payable under such programs. This exclusion includes, but is not limited to, benefits provided by the Veterans Administration for care rendered for a service-related disability or any state or federal Hospital services for which the Member is not legally obligated to pay.

COMPLICATIONS FROM NON-COVERED SERVICES

Complications arising from a Member's receipt or use of services, Medical Supplies or other treatment that are not Benefits.

CONTRACEPTIVES

Medical Supplies, services, devices or Prescription Drugs of any type even those dispensed by a prescription, for the purpose of contraception, except as specified on the Schedule of Benefits.

COPYING CHARGES

Fees for copying or production of medical records and/or claims filing.

COSMETIC AND RECONSTRUCTIVE SERVICES

A. This Plan of Benefits excludes cosmetic or reconstructive procedures, and any related services or Medical Supplies, which alter appearance but do not restore or improve impaired physical function. Examples of services that are cosmetic or reconstructive which are not covered include, but are not limited to, the following:

   1. Rhinoplasty (nose);
   2. Mentoplasty (chin);
   3. Rhytidoplasty (face lift);
   4. Glabellar rhytidoplasty (forehead lift);
   5. Surgical planing (dermabrasion);
   6. Blepharoplasty (eyelid);
   7. Mammoplasty (reduction, suspension or augmentation of the breast);
   8. Superficial chemosurgery (chemical peel of the face);
   9. Rhytidectomy (abdomen, legs, hips, buttocks or elsewhere including lipectomy or adipectomy).

B. A cosmetic or reconstructive service may, under certain circumstances, be considered restorative in nature for which Benefits are available but only if the following requirements are met:

   1. The service is intended to correct, improve or restore a bodily function; or,
   2. The service is intended to correct, improve or restore a malappearance or deformity that was caused by physical injury or accident, congenital anomaly or covered Surgical Service; and,
   3. The proposed service is Preauthorized.

CRANIAL ORTHOTICS

Adjustable cranial orthoses (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling surgery.

CUSTODIAL CARE

Services or supplies related to Custodial Care, except as specified on the Schedule of Benefits.

DENTAL SERVICES

Any dental procedures involving tooth structures, excision or extraction of teeth, gingival tissue, alveolar process, dental X-rays, preparation of mouth for dentures, or other procedures of dental origin. However, that such procedures may be covered if the need for dental services results from an accidental injury within six (6) months prior to the date of such services.

EYEGLASSES

Eyeglasses or contact lenses of any type, even those dispensed by a prescription (except after cataract surgery).

FOOD SUPPLEMENTS

Orthomolecular therapy, including infant formula, nutrients, vitamins and food supplements. Enteral feedings when not a sole source of nutrition, except as specified on the Schedule of Benefits.

FOOT CARE

Routine foot care such as paring, trimming or cutting of nails, calluses or corns, except in conjunction with diabetic foot care.

HAIR REPLACEMENTS

Wigs, hairpieces and any other artificial substitute for scalp hair.

HUMAN ORGAN AND TISSUE TRANSPLANTS

Human organ and tissue transplants that are not:

1. Preauthorized, if required, as set forth on the Schedule of Benefits;
2. Performed by a Provider as designated by the Corporation; and,
3. Listed as covered on the Schedule of Benefits.

HYPNOTISM

Hypnotism treatment or services, except as specified on the Schedule of Benefits.

ILLEGAL ACTS

Any illness or injury received while committing or attempting to commit a felony or while engaging or attempting to engage in an illegal act or occupation.

IMPACTED TOOTH REMOVAL

Services or Medical Supplies for the removal of impacted teeth.

IMPOTENCE

Services, supplies or drugs related to any treatment for impotence, including but not limited to penile implants.

INCAPACITATED DEPENDENTS

Any service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum dependent child age, unless covered under a prior Plan.

INPATIENT DIAGNOSTIC AND EVALUATIVE PROCEDURES

Inpatient care and related Provider Services rendered in conjunction with an Admission which is principally for diagnostic studies or evaluative procedures that could have been performed on an outpatient basis are not covered unless the Member's medical condition alone required Admission.

INTOXICATION OR DRUG USE

Any service (other than Substance Use Disorder Services), Medical Supplies, charges or losses resulting from a Member being Legally Intoxicated or under the influence of alcohol, any drug or other substance or taking some action the purpose of which is to create a euphoric state or alter consciousness. The Member, or Member's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request by the Corporation. If the Member refuses to provide these test results, no Benefits will be provided.

INVESTIGATIONAL OR EXPERIMENTAL SERVICES

Services or supplies or drugs that are Investigational or Experimental.

LIFESTYLE IMPROVEMENT SERVICES

Services or supplies relating to lifestyle improvements, including, but not limited to, physical fitness programs.

LONG-TERM CARE SERVICES

Admissions or portions thereof for long-term care, including:

1. Rest care;

2. Care to assist a Member in the performance of activities of daily living (including, but not limited to, walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication);

3. Custodial or long-term care; or,

4. Psychiatric or Substance Use Disorder treatment, including, but not limited to, therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes.

MEMBERSHIP DUES AND OTHER FEES

Amounts payable (whether in the form of initiation fees, annual dues or otherwise) for membership or use of any gym, workout center, fitness center, club, golf course, wellness center, health club, weight control organization or other similar entity or payable to a trainer of any type, except as specified on the Schedule of Benefits.

MOTORIZED WHEELCHAIRS OR POWER OPERATED VEHICLES

Motorized wheelchairs or power operated vehicles, such as scooters for mobility outside of the home setting, except as specified on the Schedule of Benefits. Coverage for these devices to assist with mobility in the home setting is subject to the establishment of Medical Necessity.

NOT MEDICALLY NECESSARY SERVICES OR SUPPLIES

Any service or supply that is not Medically Necessary. However, if a service is determined to be not Medically Necessary because it was not rendered in the least costly setting, Benefits will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.

OBESITY RELATED PROCEDURES

1. Services, supplies, treatment or medication for the management of obesity or weight reduction, except as specified on the Schedule of Benefits.

2. Also, the treatment or correction of complications from obesity-related treatment, except as specified on the Schedule of Benefits. This includes the reversal of obesity-related treatments and reconstructive procedures necessitated by weight loss.

3. Membership fees to weight control programs, except as specified on the Schedule of Benefits.

ORTHOGNATHIC SURGERY

Any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication or orthognathic deformities, regardless of cause, except as specified on the Schedule of Benefits.

OUTPATIENT SERVICES THAT ARE NOT PREAUTHORIZED

If Preauthorization is not received for an otherwise Covered Expense related to an outpatient service, Benefits may be reduced as set forth on the Schedule of Benefits.

OVER-THE-COUNTER DRUGS

Drugs that are available on an over-the-counter basis or are otherwise available without a prescription, except for Over-the-Counter Drugs that are designated as Prescription Drugs by the Corporation, listed as covered on the PDL accordingly and are prescribed by a Provider.

PAIN MANAGEMENT

Services, supplies or charges for any kind of pain management, including but not limited to, wellness or alternative treatment programs, acupuncture, massage therapy, Transcutaneous Electrical Nerve Stimulation (TENS) unit therapy and hypnotism. The Corporation may, in its discretion under certain limited circumstances, approve services for a multi-disciplinary pain management program, as defined herein. A multi-disciplinary pain management program is a program that includes physicians of different specialties and non-physician Providers who specialize in the assessment and management of patients with a range of painful diagnoses and chronic pain, the purpose of which is intended to provide the interventions needed to allow the patients to develop pain coping skills and discontinue analgesic medication. Services, supplies or charges for a multi-disciplinary pain management program must be Preauthorized in advance. Preauthorization approval shall be on a case by case basis, in the discretion of the Corporation, and contingent upon such program, and the Providers offering such program, complying with the Corporation's Provider credentialing and medical policy requirements, which may change from time to time based on new evidence-based medical information available to the Corporation. The Member is solely responsible for seeking Preauthorization in advance, regardless of the state of location of the Provider offering the multi-disciplinary pain management program.

PARTICIPATING PROVIDER CHARGES NOT PREAUTHORIZED

For any service that requires Preauthorization, the penalty for not obtaining Preauthorization will vary from state to state, depending on the contractual agreements the BCBS Plan has with its local Providers in that state. Generally, this is a penalty to the Provider, but in some cases, the Member may be held liable.

PHYSICAL THERAPY ADMISSIONS

All Admissions solely for physical therapy, except as provided in Article II.

PREOPERATIVE ANESTHESIA CONSULTATION

Charges for preoperative anesthesia consultation.

PRESCRIPTION DRUG COPAY CARD

Prescription Drugs, as determined by the Corporation, for which the costs and associated services are in any way paid for, through or under a pharmaceutical manufacturer or other discount card or coupon program on behalf of the Member.

PRESCRIPTION DRUGS

Charges for Prescription Drugs.

PROVIDER CHARGES

Charges by a Provider for blood and blood derivatives and for charges for Prescription Drugs or Specialty Drugs that are not consumed at the Provider's office.

PSYCHOLOGICAL AND EDUCATIONAL TESTING

Psychological or educational diagnostic testing to determine job or occupational placement, school placement or for other educational purposes or to determine if a learning disability exists.

PULMONARY REHABILITATION

Pulmonary rehabilitation, except in conjunction with a covered lung transplant, and except as specified on the Schedule of Benefits.

RADIOLOGY MANAGEMENT

All charges for MRIs, MRAs, CAT scans or PET scans in an office or outpatient facility when the required Preauthorization is not obtained.

REPATRIATION

Services and supplies received as the result of transporting a Member, regardless of cause, from a foreign country for the convenience of the Member or to the Member's residence in the United States.

SELF-INFLICTED INJURY

Services and supplies received as the result of any intentionally self-inflicted injury that does not result from a medical condition or domestic violence.

SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS

Medical Supplies or services or charges for the diagnosis or treatment of learning disabilities, perceptual disorders, intellectual disabilities, vocational rehabilitation, animal assisted therapy, eye movement desensitization and reprocessing (EMDR), behavioral therapy for solitary maladaptive habits or rapid opiate detoxification, except as specified on the Schedule of Benefits.

SERVICES FOR COUNSELING OR PSYCHOTHERAPY

Counseling and psychotherapy services for the following conditions are not covered:

1. Feeding and eating disorders in early childhood and infancy;
2. Tic disorders, except when related to Tourette's disorder;
3. Mental disorders due to a general medical condition;
4. Sexual function disorders;
5. Medication induced movement disorders; or,
6. Nicotine dependence, except as specified on the Schedule of Benefits.

SERVICES NOT LISTED AS COVERED BENEFITS

Medical Supplies or services or other items not specifically listed as a Benefit in Article II of this Plan of Benefits or on the Schedule of Benefits.

SERVICES PRIOR TO MEMBER EFFECTIVE DATE OR PLAN OF BENEFITS EFFECTIVE DATE

Any charges for Medical Supplies or services rendered to the Member prior to the Member's effective date, the Employer's Effective Date or after the Member's coverage terminates.

SERVICES RENDERED BY FAMILY

Any Medical Supplies or services rendered by a Member to him or herself or rendered by a Member's immediate family (parent, child, spouse, brother, sister, grandparent or in-law).

SEX CHANGE

Any Medical Supplies, services or charges incurred for consultation, therapy, surgery or any procedures related to changing a Member's sex, except as specified in Article II.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDER

Any service for the treatment of dysfunctions or derangements of the temporomandibular joint, regardless of cause. This exclusion also applies to orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint, regardless of cause, except as specified on the Schedule of Benefits.

TRAVEL

Travel, whether or not recommended by a Provider unless directly related to human organ or tissue transplants when Preauthorized and except as specified on the Schedule of Benefits.

VISION CARE SERVICES

Any Medical Supply or service rendered to a Member for vision care.

WORKERS' COMPENSATION/ON THE JOB INJURIES

This Plan of Benefits does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage is available under any Workers' Compensation Act or similar federal or state law regarding on the job injuries is required or is otherwise available for the Member. Benefits will not be provided under this Plan of Benefits if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member or Employer elected exemption from available workers' compensation coverage, waived entitlement to workers' compensation benefits for which he/she is eligible, failed to timely file a claim for workers' compensation benefits or the Member sought treatment for the injury or illness from a Provider which is not authorized by the Member's Employer or Workers' Compensation Carrier.

If the Group Health Plan pays Benefits for an injury or illness and the Group Health Plan determines the Member also received a recovery from the Employer or Employer's Workers' Compensation Carrier by means of a settlement, judgment or other payment for the same injury or illness, the Group Health Plan shall have the right of recovery as outlined in Article VII of this Plan of Benefits.

ARTICLE IV - COORDINATION OF BENEFITS

A. APPLICABILITY

The coordination of benefits rules are intended to prevent duplicate payments from different Plans that otherwise cover a Member for the same Benefits. The rules determine which is the Primary Plan and which is the Secondary Plan.

Generally, unless a specific rule applies, where a claim is submitted for payment under this Plan of Benefits and one (1) or more other Plans, this Plan of Benefits is the Secondary Plan. Additionally, special rules for the coordination of benefits with Medicare may also apply. The Group Health Plan does not coordinate benefits with individual Plans.

B. COORDINATION OF BENEFITS WITH AUTO INSURANCE

This is a self-funded ERISA Plan which does not provide benefits for claims which are paid or payable under automobile insurance coverage. Automobile insurance coverage shall include, but is not limited to, no-fault, personal injury protection, medical payments, liability, uninsured and underinsured coverage, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.

Although benefits for claims which are paid or payable under automobile insurance coverage are not covered by this Plan of Benefits, the Group Health Plan or Corporation may, in its sole discretion, agree to extend Benefits to a Member for the injury or illness. In this instance, if a Member has automobile no-fault, personal injury protection or medical payments coverage, or if such coverage is extended to the Member through a group or their own automobile insurance carrier, that coverage is primary to the Group Health Plan. The Group Health Plan will always be secondary to automobile no-fault, personal injury protection or medical payments coverage plans and the Group Health Plan will coordinate benefits for claims which are payable under those automobile policies.

If the Member resides in a state where automobile no-fault, personal injury protection or medical payments coverage is mandatory and the Member does not have the state mandated automobile coverage, the Group Health Plan will deny Benefits up to the amount of the state mandated automobile coverage.

This coordination of benefits provision applies whether or not the Member submits a claim under the automobile no-fault, personal injury protection or medical payments coverage.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Group Health Plan or Corporation of an injury or illness for which automobile insurance coverage may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;

2. Execute and deliver to the Corporation an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

3. Deliver to the Group Health Plan or Corporation a copy of your Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;

4. Deliver to the Group Health Plan or Corporation a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so; and,

5. Cooperate fully with the Group Health Plan or Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Group Health Plan or Corporation.

Failure to cooperate with the Group Health Plan as required under this section will entitle the Group Health Plan or Corporation to invoke the Auto Accident Exclusion and deny payment for all claims relating to the injury or illness up to the amount of available or state mandated coverage.

C. ORDER OF DETERMINATION RULES FOR EMPLOYEE MEMBERS

When a Member's claim is submitted under the Group Health Plan and another Plan, the Group Health Plan is a Secondary Plan unless:

1. The other Plan has rules coordinating its benefits with those of the Group Health Plan;

2. There is a statutory requirement establishing that the Group Health Plan is the Primary Plan and such statutory requirement is not pre-empted by ERISA; or,

3. Both the other Plan's rules and the Group Health Plan's rules require that Benefits under this Plan of Benefits be determined before those of the other Plan.

D. ADDITIONAL ORDER OF DETERMINATION RULES

The coordination of benefits is determined using the first of the following rules that apply:

1. Dependents

    a. The Plan that covers an individual as an Employee or retiree is the Primary Plan.

2. Dependent Child - Parents not Separated or Divorced

When the Group Health Plan and another Plan cover the same child as a dependent then benefits are determined in the following order:

a. The Plan of the parent whose birthday falls earlier in the year (month and date) is the Primary Plan.

b. If both parents have the same birthday, the Plan that has covered a parent longer is the Primary Plan.

c. If the other Plan does not have the rule described in (a) above but instead has a rule based upon the gender of the parent and if, as a result, the Plan and the Corporation do not agree on the order of benefits, the gender rule in the other Plan will apply.

The "birthday rule" does not use the years of the parents' birth in determining which has the earlier birthday.

3. Dependent Child - Separated or Divorced Parents

If two (2) or more Plans cover a person as a dependent child of divorced, separated or unmarried parents, benefits for the child are determined in the following order:

a. First, the Plan of the parent with custody of the child;

b. Second, the Plan of the parent's spouse with the custody of the child;

c. Third, the Plan of the parent not having custody of the child; or,

d. Fourth, the Plan of the parent's spouse not having custody of the child.

Notwithstanding the foregoing, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses (or health insurance coverage) of the child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, that Plan is the Primary Plan. If the parent with responsibility for healthcare expenses has no health insurance coverage for the dependent child, but that parent's spouse does have coverage, the spouse's Plan is the Primary Plan. This paragraph does not apply with respect to any claim determination period or Plan year during which any Benefits are actually paid or provided before the Plan has actual knowledge of the existence of an applicable court decree.

If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the healthcare expenses of the child (or if the order provides that both parents are responsible), the Plans covering the child shall follow the order of determination rules outlined in Article IV(D)(2). Once the dependent child reaches the age of eighteen (18) and/or the terms of the court decree are no longer applicable, the Plan which has covered the dependent for a longer period of time will be primary.

4. Active and Inactive Employees

The benefits of the Plan that covers a person as an Employee who is neither laid off nor retired or as that Employee's dependent is the Primary Plan. If the Secondary Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Covered Expenses, this rule does not apply.

5. Medicare

   The Group Health Plan is a Primary Plan except where federal law mandates that the Group Health Plan is the Secondary Plan. Any claims where Medicare is primary must be filed by the Member after Medicare payment is made.

6. Longer and Shorter Length of Coverage

   If none of the above rules determines the order of benefits, the Plan that has covered the Member longer is the Primary Plan.

7. COBRA

   COBRA allows coverage to begin or continue under certain circumstances if the Member already has or obtains coverage under a group health Plan. In these instances, two policies may cover the Member, and the Plan providing COBRA coverage will be the Secondary Plan.

E. EFFECT ON BENEFITS OF THIS PLAN OF BENEFITS

1. The Group Health Plan as Primary Plan

   When the Group Health Plan is the Primary Plan, the Benefits shall be determined without consideration of the benefits of any other Plan.

2. The Group Health Plan as Secondary Plan

   When the Group Health Plan is a Secondary Plan, the Benefits will be reduced when the sum of the following exceeds the Covered Expenses in a Benefit Year:

   a. The Covered Expenses in the absence of this coordination of benefits provision; plus

   b. The expenses that would be payable under the other Plan, in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not a claim is made.

   When the sum of these two (2) amounts exceeds the maximum amount payable for Covered Expenses in a Benefit Year, the Covered Expenses will be reduced so that they and the Benefits payable under the Primary Plan do not total more than the Covered Expenses. When the Covered Expenses of the Group Health Plan are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of the Group Health Plan.

3. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered for purposes of determining the appropriate level of coverage available.

4. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not a Covered Expense unless the Member's Admission in a private Hospital room is Medically Necessary. When benefits are reduced under a Primary Plan because a Member does not comply with the Primary Plan's requirements, the amount of such reduction in benefits will not be a Covered Expense.

F. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

The Group Health Plan (including through the Corporation) is entitled to such information as it deems reasonably necessary to apply these coordination of benefit provisions, and the Member and the Employer must provide any such information as reasonably requested.

G. PAYMENT

A payment made under another Plan may include an amount that should have been paid under the Group Health Plan. In such a case, the Group Health Plan may pay that amount to the organization that made such payment. That amount will then be treated as though it has been paid under the Group Health Plan. The term "payment" includes providing Benefits in the form of services, in which case "payment" means the reasonable cash value of the Benefits provided in the form of services.

H. RIGHT OF RECOVERY

If the amount of the payments made by the Group Health Plan is more than the Group Health Plan should have paid, the Group Health Plan may recover the excess or overpayment from the Member on whose behalf it has made payments, from a Provider, any group insurer, Plan, or any other person or organization contractually obligated to such Member with respect to such overpayments.

ARTICLE V – CONTINUATION OF COVERAGE

A. CONTINUATION

1. COBRA

   a. Plan Administrator and Sponsor

      The Employer is both the Plan Administrator and Plan Sponsor for the Group Health Plan. The Employer agrees to offer continuation of coverage pursuant to the provisions of COBRA, if required, to eligible Members while the Group Health Plan is in force. COBRA requires the Employer to allow eligible individuals to continue their health coverage for eighteen (18), twenty-nine (29) or thirty-six (36) months, depending on the Qualifying Event.

   b. Disabled Members

      To be eligible for up to twenty-nine (29) months of continuation of coverage due to disability, an Employee or dependent who:

      i. is determined to be disabled under Title II or XVI of the Social Security Act,

      ii. with a disability onset date either before the COBRA event or within the first sixty (60) days of the COBRA continuation coverage must provide a copy of the notice of the determination of disability to the Employer within:

         aa. sixty (60) days of the determination of disability; and,

         bb. before the end of the first eighteen (18) months of COBRA coverage.

      Such Employee or dependent must also notify the Employer within thirty (30) days of any determination that the Employee or dependent is no longer disabled.

   c. Notice of Qualifying Event by the Member

      Each Member is responsible for notifying the Employer within sixty (60) days of such Member's Qualifying Event due to divorce, legal separation or when a dependent ceases dependency. If the Member does not give such notice, the Member is not entitled to continuation coverage.

d. Notice by the Employer to the Member

The Employer must notify the COBRA Administrator no later than thirty (30) days after the date the Member loses coverage due to a COBRA event. The COBRA Administrator must send a COBRA Election Notice to each Member no later than fourteen (14) days after receipt of the notice from the Employer. Notice to the dependent spouse is deemed notice to any dependent of the spouse.

e. Election of Coverage

Continuation coverage is not automatic. The Member must elect continuation coverage within sixty (60) days of the later of:

i. The date the Member's coverage under the Group Health Plan ceases because of the Qualifying Event;

ii. The date the Member is sent notice by the Employer of the right to elect continuation coverage; or,

iii. The date the Member becomes an "eligible individual" (as that term is used in the Trade Act of 2002) provided that such election is made not later than six (6) months after the Qualifying Event that gives rise to eligibility under the Trade Act of 2002 (TAA).

f. Premium Required

The Member will be required to pay a premium for the continuation coverage and shall have the option to make payment in monthly installments. The Member has forty-five (45) days from the date of election to pay the first premium, which includes the period when coverage commenced, regardless of the date that the first premium is due.

The TAA created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of a percentage of the premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll free at 866-628-4282. TTD/TTY callers may call toll free at 866-626-4282. More information about the TAA is also available at www.doleta.gov/tradeact/.

g. Length of COBRA Coverage

The maximum period for continuation coverage for a Qualifying Event involving termination of employment or a reduction in hours is generally eighteen (18) months. An Employee or dependent who is determined to be disabled under Title II or XVI of the Social Security Act before the COBRA event or within the first sixty (60) days of COBRA continuation coverage is entitled to twenty-nine (29) months of continuation coverage, but only if such Employee or dependent has provided notice of the determination of disability within sixty (60) days after determination is issued and before the end of eighteen (18) months of coverage. If a second Qualifying Event occurs within this period of continuation coverage, the coverage for any affected dependent who was a Member under the Group Health Plan both at the time of the first and the second Qualifying Events may be extended up to thirty-six (36) months from the first Qualifying Event. For all other Qualifying Events, the maximum period of coverage is thirty-six (36) months. Below is a list of circumstances and the period of COBRA coverage for each circumstance.

i. Eighteen (18) months for Employees whose working hours are reduced, from full-time to part-time for instance and any dependents who also lose coverage for this reason.

ii. Eighteen (18) months for Employees who voluntarily quit work and any dependents who also lose coverage for this reason.

iii. Eighteen (18) months for Employees who are part of a layoff and any dependents who also lose coverage for this reason.

iv. Eighteen (18) months for Employees who are fired, unless the firing is due to gross misconduct, and any dependents who also lose coverage for this reason.

v. Twenty-nine (29) months for Employees and all covered dependents who are determined to be disabled under the Social Security Act during the first sixty (60) days after termination of employment or reduction of hours of employment. Notice of the Social Security Disability determination must be given to the COBRA Administrator within sixty (60) days of the determination of disability and before the end of the first eighteen (18) months of continuation of coverage.

vi. Thirty-six (36) months for Employees' widows or widowers and their dependent children.

vii. Thirty-six (36) months for legally separated or divorced husbands or wives and their dependent children.

viii. Thirty-six (36) months for dependent children who lose coverage because they no longer meet the Plan's definition of a dependent child.

ix. Thirty-six (36) months for dependents who are not eligible for Medicare when the Employee is eligible for Medicare and no longer has coverage with the Employer. This does not apply to any Employees or their dependents if the Employee voluntarily quit work. See Article V(A)(1)(g)(ii) of this section for coverage for Employees who voluntarily quit.

x. For Plans providing coverage for retired Employees and their dependents, a special rule applies for such persons who would lose coverage due to the Employer filing for Title 11 Bankruptcy (loss of coverage includes a substantial reduction of coverage within a year before or after the bankruptcy filing). Upon occurrence of such an event, retired Employees and their eligible dependents may continue their coverage under the Plan until the date of death of the retiree. If a retiree dies while on this special continued coverage, surviving dependents may elect to continue coverage for up to thirty-six (36) additional months.

2. USERRA

a. In any case in which an Employee or any of such Employee's dependents has coverage under the Plan of Benefits and such Employee is not actively at work by reason of active duty service in the uniformed services, the Employee may elect to continue coverage under the Plan of Benefits as provided in this Article V(A)(2). The maximum period of coverage of the Employee and such Employee's dependents under such an election shall be the lesser of:

i. The twenty-four (24) month period beginning on the date on which the Employee's absence from being actively at work by reason of active duty service in the uniformed services begins; or,

ii. The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under USERRA.

The continuation of coverage period under USERRA will be counted toward any continuation of coverage period available under COBRA.

b. An Employee who elects to continue coverage under this section of this Plan of Benefits must pay one hundred and two percent (102%) such Employee's normal premium. Except that, in the case of an Employee who performs service in the uniformed services for less than thirty-one (31) days, such Employee will pay the normal contribution for the thirty-one (31) days.

c. An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Group Health Plan upon re-employment. Except as otherwise provided in this Article upon re-employment and reinstatement of coverage no new exclusion or probationary period will be imposed in connection with the reinstatement of such coverage if an exclusion would normally have been imposed. This Article applies to the Employee who is re-employed and to a dependent who is eligible for coverage under this Plan of Benefits by reason of the reinstatement of the coverage of such Employee.

d. The Article V(A)(2)(c) shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

B. QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Group Health Plan shall pay Covered Expenses in accordance with the applicable requirements of any Qualified Medical Child Support Order.

1. Procedural Requirements

a. Timely Notifications and Determinations

In the case of any Medical Child Support Order received by the Group Health Plan:

i. The Employer shall promptly notify the Employee and each Alternate Recipient of the receipt of the Medical Child Support Order and the Employer's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders; and,

ii. Within a reasonable period after receipt of such Qualified Medical Child Support Order, the Employer shall determine whether such order is a Qualified Medical Child Support Order and notify the Employee and each Alternate Recipient of such determination.

b. Establishment of Procedures for Determining Qualified Status of Orders

The Employer shall establish reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of Covered Expenses under such qualified orders. The Employer's procedures:

i. Shall be in writing;

ii. Shall provide for the notification of each person specified in a Medical Child Support Order as eligible to receive Benefits under the Plan of Benefits (at the address included in the Medical Child Support Order) of the Employer's procedures promptly upon receipt by the Plan Administrator of the Medical Child Support Order; and,

iii. Shall permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

c. Actions Taken by Fiduciaries

If a fiduciary for the Group Health Plan acts in accordance with these procedural requirements in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the Group Health Plan obligation to the Member and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

2. Treatment of Alternate Recipients

a. Under ERISA

A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a beneficiary under the Group Health Plan for purposes of any provisions of ERISA, as amended, and shall be treated as a participant under the reporting and disclosure requirements of ERISA.

b. Direct Provision of Benefits Provided to Alternate Recipients

Any payment for Covered Expenses made by the Group Health Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

c. Plan Enrollment and Payroll Deductions

If an Employee remains covered under the Group Health Plan but fails to enroll an Alternate Recipient under the Plan of Benefits after receiving notice of the Qualified Medical Child Support Order from the Employer, the Employer shall enroll the Alternate Recipient and deduct the additional premium from the Employee's paycheck.

d. Termination of Coverage

Except for any coverage continuation rights otherwise available under the Group Health Plan, the coverage for the Alternate Recipient shall end on the earliest of:

i. The date the Employee's coverage ends;

ii. The date the Qualified Medical Child Support Order is no longer in effect;

iii. The date the Employee obtains other comparable health coverage through another insurer or Plan to cover the Alternate Recipient; or,

iv. The date the Employer eliminates family health coverage for all of its Employees.

ARTICLE VI – SUBROGATION AND REIMBURSEMENT

A. BENEFITS SUBJECT TO THIS PROVISION

This provision shall apply to all Benefits provided under any section of the Plan of Benefits. All Benefits under this Plan of Benefits are being provided by a self-funded ERISA plan.

B. STATEMENT OF PURPOSE

Subrogation and Reimbursement represent significant Group Health Plan assets and are vital to the financial stability of the Group Health Plan. Subrogation and Reimbursement recoveries are used to pay future claims by other Group Health Plan members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of the Group Health Plan. The Group Health Plan has a fiduciary obligation under the Employee Retirement Income Security Act (ERISA) to pursue and recover these Group Health Plan assets to the fullest extent possible.

C. DEFINITIONS

1. Another Party

Another Party shall mean any individual or entity, other than this Group Health Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Member's injuries or illness.

Another Party shall include the party or parties who caused the injuries or illness; the liability insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Member's own insurance coverage, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other insurer; a workers' compensation insurer or governmental entity; or, any other individual, corporation, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

2. Member

   As it relates to the Subrogation and Reimbursement Provision, a Member shall mean any person, dependent or representatives, other than the Group Health Plan, who is bound by the terms of the Subrogation and Reimbursement Provision herein. A Member shall include but is not limited to any beneficiary, dependent, spouse or person who has or will receive Benefits under the Group Health Plan, and any legal or personal representatives of that person, including parents, guardians, attorneys, trustees, administrators or executors of an estate of a Member, and heirs of the estate.

3. Recovery

   Recovery shall mean any and all monies identified, paid or payable to the Member through or from Another Party by way of judgment, award, settlement, covenant, release or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. A Recovery exists as soon as any fund is identified as compensation for a Member from Another Party. Any recovery shall be deemed to apply, first, for Reimbursement of the Group Health Plan's lien. The amount owed from the Recovery as Reimbursement of the Group Health Plan's lien is an asset of the Group Health Plan.

4. Reimbursement

   Reimbursement shall mean repayment to the Group Health Plan of recovered medical or other Benefits that it has paid toward care and treatment of the injuries or illness for which there has been a Recovery.

5. Subrogation

   Subrogation shall mean the Group Health Plan's right to pursue the Member's claims for medical or other charges paid by the Group Health Plan against Another Party.

D. WHEN THIS PROVISION APPLIES

This provision applies when a Member incurs medical or other charges related to injuries or illness caused in part or in whole by the act or omission of the Member or another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness; or Another Party may otherwise make a payment without an admission of liability. If so, the Member may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Member agrees, as a condition of receiving Benefits from the Group Health Plan, to transfer to the Group Health Plan all rights to recover damages in full for such Benefits.

E. DUTIES OF THE MEMBER

The Member will execute and deliver all required instruments and papers provided by the Group Health Plan or Corporation, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Group Health Plan's rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Group Health Plan for the injuries or illness. The Group Health Plan or Corporation may determine, in its sole discretion, that it is in the Group Health Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Group Health Plan will remain entitled to Subrogation and Reimbursement. In addition, the Member will do nothing to prejudice the Group Health Plan's right to Subrogation and Reimbursement and acknowledges that the Group Health Plan precludes operation of the made-whole and common-fund doctrines. A Member who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the portion of the Recovery subject to the Group Health Plan's lien to the Group Health Plan under the terms of this provision. A Member who receives any such Recovery and does not immediately tender the Group Health Plan's portion of the Recovery to the Group Health Plan will be deemed to hold the Group Health Plan's portion of the Recovery in constructive trust for the Group Health Plan, because the Member is not the rightful owner of the Group Health Plan's portion of the Recovery and should not be in possession of the Recovery until the Group Health Plan has been fully reimbursed. The portion of the Recovery owed by the Member for the Group Health Plan's lien is an asset of the Group Health Plan.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Group Health Plan or Corporation of an injury or illness for which Another Party may be liable, legally responsible or otherwise makes a payment in connection with the injuries or illness;

2. Execute and deliver to the Corporation an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

3. Deliver to the Group Health Plan or Corporation a copy of the Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;

4. Deliver to the Group Health Plan or Corporation a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so;

5. Authorize the Group Health Plan or Corporation to sue, compromise and settle in the Member's name to the extent of the amount of medical or other Benefits paid for the injuries or illness under the Group Health Plan and the expenses incurred by the Group Health Plan or Corporation in collecting this amount, and assign to the Group Health Plan the Member's rights to Recovery when this provision applies;

6. Include the amount paid for Benefits as a part of the damages sought against Another Party. Immediately reimburse the Group Health Plan or Corporation, out of any Recovery made from Another Party, the amount of medical or other Benefits paid for the injuries or illness by the Group Health Plan up to the amount of the Recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

7. Immediately notify the Group Health Plan or Corporation in writing of any proposed settlement and obtain the Group Health Plan or Corporation's written consent before signing any release or agreeing to any settlement; and,

8. Cooperate fully with the Group Health Plan or Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Group Health Plan or Corporation.

F. FIRST PRIORITY RIGHT OF SUBROGATION AND/OR REIMBURSEMENT

Any amounts recovered will be subject to Subrogation or Reimbursement. The Member's submission of claims for illnesses or injury caused by Another Party constitutes the Member's agreement to the terms of this provision and the Member's grant to the Plan of a first priority equitable lien by agreement. The Plan's right to recover exists regardless of whether it is based on Subrogation or Reimbursement.

The Group Health Plan will be subrogated to all rights the Member may have against that other person or Another Party and will be entitled to first priority Reimbursement out of any Recovery to the extent of the Group Health Plan's payments. In addition, the Group Health Plan shall have a first priority equitable lien against any Recovery to the extent of Benefits paid and to be payable in the future. The Group Health Plan's first priority equitable lien supersedes any right that the Member may have to be "made whole." In other words, the Group Health Plan is entitled to the right of first Reimbursement out of any Recovery the Member procures or may be entitled to procure regardless of whether the Member has received full compensation for any of his or her damages or expenses, including attorneys' fees or costs and regardless of whether the Recovery is designated as payment for medical expenses or otherwise. Additionally**,** the Group Health Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative or contributory negligence, limits of collectability or responsibility, characterization of Recovery as pain and suffering or otherwise. As a condition to receiving Benefits under the Group Health Plan and Plan of Benefits, the Member agrees that acceptance of Benefits is constructive notice of this provision.

G. WHEN A MEMBER RETAINS AN ATTORNEY

An attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) for an injury or illness in which the Group Health Plan has paid or will pay Benefits, has an absolute obligation to immediately tender the portion of the Recovery subject to the Group Health Plan's equitable lien to the Group Health Plan under the terms of this provision. As a possessor of a portion of the Recovery, the Member's attorney holds the Recovery as a constructive trustee and fiduciary and is obligated to tender the Group Health Plan's portion of the Recovery immediately over to the Group Health Plan. A Member's attorney who receives any such Recovery and does not immediately tender the Group Health Plan's portion of the Recovery to the Group Health Plan will be deemed to hold the Recovery in constructive trust for the Group Health Plan, because neither the Member nor the attorney is the rightful owner of the portion of the Recovery subject to the Group Health Plan's lien. The portion of the Recovery owed for the Group Health Plan's lien is an asset of the Group Health Plan.

If the Member retains an attorney, the Member's attorney must recognize and consent to the fact that this provision precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine against the Group Health Plan in his or her pursuit of Recovery. The Group Health Plan will not pay the Member's attorneys' fees and costs associated with the recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Member's attorneys' fees and costs, without the expressed written consent of the Corporation.

H. WHEN THE MEMBER IS A MINOR OR IS DECEASED OR INCAPACITATED

This Subrogation and Reimbursement Provision will apply with equal force to the parents, trustees, guardians, administrators, or other representatives of a minor, incapacitated, or deceased Member and to the heirs or personal and legal representatives, regardless of applicable law. No representative of a Member listed herein may allow proceeds from a Recovery to be allocated in a way that reduces or minimizes the Group Health Plan's claim by arranging for others to receive proceeds of any judgment, award, settlement, covenant, release or other payment or releasing any claim in whole or in part without full compensation therefore or without the prior written consent from the Group Health Plan or Corporation.

I. WHEN A MEMBER DOES NOT COMPLY

When a Member does not comply with the provisions of this section, the Group Health Plan or Corporation shall have the authority, in its sole discretion, to deny payment of any claims for Benefits by the Member and to deny or reduce future Benefits payable (including payment of future Benefits for other injuries or illnesses) under the Plan of Benefits by the amount due as satisfaction for the Reimbursement to the Group Health Plan. The Group Health Plan or Corporation may also, in its sole discretion, deny or reduce future Benefits (including future Benefits for other injuries or illnesses) for the Member under any other group benefits plan maintained by the Employer. The reductions will equal the amount of the required Reimbursement; however, under no circumstances shall the Reimbursement, denial or reduction of Benefits exceed the amount of the Recovery. If the Group Health Plan must bring an action against a Member to enforce the provisions of this section, then the Member agrees to pay the Group Health Plan's attorneys' fees and costs, regardless of the action's outcome.

J. PRIOR RECOVERIES

In certain circumstances, a Member may receive a Recovery that exceeds the amount of the Group Health Plan's payments for past and/or present expenses for treatment of the injuries or illness that is the subject of the Recovery. In other situations, based on the extent of the Member's injuries or illness, the Member may have received a prior Recovery for treatment of the injuries or illness that is the subject of a claim for Benefits under the Group Health Plan. In these situations, the Group Health Plan will not provide Benefits for any expenses related to the injuries or illness for which compensation was provided through a current or previous Recovery. The Member is required to submit full and complete documentation of any such Recovery in order for the Group Health Plan to consider eligible expenses. To the extent a Member's Recovery exceeds the amount of the Group Health Plan's lien, the Group Health Plan is entitled to deny that amount as an offset against any claims for future Benefits relating to the injuries or illness. In those situations, the Member will be solely responsible for payment of medical bills related to the injuries or illness. The Group Health Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

The Group Health Plan or Corporation has sole discretion to determine whether expenses are related to the injuries or illness to the extent this provision applies. Acceptance of Benefits under this Plan of Benefits for injuries or illness which the Member has already received a Recovery may be considered fraud, and the Member will be subject to any sanctions determined by the Group Health Plan or Corporation, in their sole discretion, to be appropriate, including denial of present or future Benefits under this Plan of Benefits.

ARTICLE VII - WORKERS' COMPENSATION PROVISION

This Plan of Benefits does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member. Benefits will not be provided under this Plan of Benefits if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member or the Employer elected exemption from available workers' compensation coverage; waived entitlement to workers' compensation benefits for which he/she is eligible; failed to timely file a claim for workers' compensation benefits; or the Member sought treatment for the injury or illness from a Provider not authorized by the Member's Employer or Workers' Compensation carrier.

Although treatment for work-related or alleged work-related injuries or illness is excluded under this Plan of Benefits, the Group Health Plan or Corporation may, in its sole discretion, agree to extend coverage to a Member for the injury or illness. In this instance, the Member agrees, as a condition of receiving Benefits, to reimburse the Group Health Plan in full from any workers' compensation recovery as described herein. The Member further agrees as a condition of receiving Benefits, to execute and deliver all required instruments and papers provided by the Group Health Plan or Corporation, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Group Health Plan's right of recovery, before any medical or other Benefits will be paid by the Group Health Plan for the injuries or illness. The Group Health Plan or Corporation may determine, in its sole discretion, that it is in the Group Health Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Group Health Plan will remain entitled to reimbursement from any workers' compensation recovery the Member may receive.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Group Health Plan or Corporation of an injury or illness for which his or her Employer and/or Employers' Workers' Compensation carrier may be liable, legally responsible or otherwise makes a payment in connection with the injuries or illness;

2. Execute and deliver to the Corporation an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

3. Deliver to the Group Health Plan or Corporation a copy of the police report, incident or accident report or any other reports issued as a result of the injury or illness within ninety (90) days of being requested to do so;

4. Assert a claim or lawsuit against the Employer and/or Employer's Workers' Compensation carrier or any other insurance coverage to which the Member may be entitled;

5. Include the amount paid for as a part of the damages sought against his or her Employer and/or Employer's Workers' Compensation carrier. Immediately reimburse the Group Health Plan, out of any recovery made from the Employer and/or Employer's Workers' Compensation carrier, the amount of medical or other Benefits paid for the injuries or illness by the Group Health Plan up to the amount of the recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

6. Immediately notify the Group Health Plan or Corporation in writing of any proposed settlement and obtain the Group Health Plan or Corporation's written consent before signing any release or agreeing to any settlement; and,

7. Cooperate fully with the Group Health Plan or Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Group Health Plan or Corporation.

The Group Health Plan or Corporation has sole discretion to determine whether claims for Benefits submitted under the Plan of Benefits are related to the injuries or illness to the extent this provision applies. If the Group Health Plan or Corporation pays Benefits for an injury or illness and the Group Health Plan or Corporation determines the Member also received a recovery from the Employer and/or Employer's Workers' Compensation carrier by means of a settlement, judgment or other payment for the same injury or illness, the Member shall reimburse the Group Health Plan from the recovery for all Benefits paid by the Group Health Plan relating to the injury or illness. However, under no circumstances shall the Member's reimbursement to the Group Health Plan exceed the amount of such recovery.

If the Member receives a recovery from the Employer and/or Employer's Workers' Compensation carrier, the Group Health Plan's right of reimbursement from the recovery will be applied even if: liability is denied, disputed or is made by means of a compromised, doubtful and disputed, clincher or other settlement; no final determination is made that the injury or illness was sustained in the course of or resulted from the Member's employment; the amount of workers' compensation benefits due to medical or healthcare is not agreed upon or defined by the Member, Employer or the Workers' Compensation carrier; or the medical or healthcare benefits are specifically excluded from the settlement or compromise.

Failure to reimburse the Group Health Plan from the recovery as required under this section will entitle the Group Health Plan or Corporation to invoke the Workers' Compensation exclusion and deny payment for all claims relating to the injury or illness.

ARTICLE VIII - CLAIMS FILING AND APPEAL PROCEDURES

A. CLAIMS FILING PROCEDURES

1. Where a Participating Provider renders services, generally the Participating Provider should either file the claim on a Member's behalf or provide an electronic means for the Member to file a claim while the Member is in the Participating Provider's office. However, the Member is responsible for ensuring that the claim is filed.

2. For Benefits not provided by a Participating Provider, the Member is responsible for filing claims with the Corporation. When filing the claims, the Member will need the following:

   a. A claim form for each Member. Members can get claim forms from a Member services representative at the telephone number indicated on the Identification Card or via the Corporation's website, www.MyHealthToolkitFL.com.

   b. Itemized bills from the Provider (s). These bills should contain all the following:

      i. Provider's name and address;

      ii. Member's name and date of birth;

      iii. Member's Identification Card number;

      iv. Description and cost of each service;

      v. Date that each service took place; and,

      vi. Description of the illness or injury and diagnosis.

c. Members must complete each claim form and attach the itemized bill(s) to it. If a Member has other insurance that already paid on the claim(s), the Member should also attach a copy of the other Plan's EOB notice.

d. Members should make copies of all claim forms and itemized bills for the Member's records since they will not be returned. Claims should be mailed to the Corporation's address listed on the claim form.

3. Except in the absence of legal capacity, claims must be filed no later than twelve (12) months following the date services were received.

4. Receipt of a claim by the Corporation will be deemed written proof of loss and will serve as written authorization from the Member to the Corporation to obtain any medical or financial records and documents useful to the Corporation. The Corporation, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to the Corporation in support of a Member's claim will be deemed to be acting as the agent of the Member. If the Member desires to appoint an authorized representative in connection with such Member's claims, the Member should contact the Corporation for an authorized representative form.

5. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims and Concurrent Care claims. The Group Health Plan will make a determination for each type of claim within the following time periods:

   a. Pre-Service Claim

      i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.

      ii. If a Pre-service Claim is improperly filed or otherwise does not follow applicable procedures, the Member will be sent notification within five (5) days of receipt of the claim.

      iii. An extension of fifteen (15) days is permitted if the Corporation (on behalf of the Group Health Plan) determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary the Corporation will notify the Member within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference Article VIII(B) for details regarding the appeals process.

b. Urgent Care Claim

i. A determination will be sent to the Member in writing or in electronic form as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

ii. If the Member's Urgent Care Claim is determined to be incomplete, the Member will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Member will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

iii. If the Member requests an extension of urgent care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Member will be notified within twenty-four (24) hours of receipt of the request for an extension.

c. Post-Service Claim

i. A determination will be sent within a reasonable time period but no later than thirty (30) days from receipt of the claim.

ii. An extension of fifteen (15) days may be necessary if the Corporation (on behalf of the Group Health Plan) determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary, the Corporation will notify the Member within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference Article VIII(B) for details regarding the appeals process.

d. Concurrent Care Claim

The Member will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Member time to appeal the decision before the Benefits are reduced or terminated.

6. Notice of Determination

a. If the Member's claim is filed properly and the claim is in part or wholly denied, the Member will receive notice of an Adverse Benefit Determination, in a culturally and linguistically appropriate manner, that will:

i. Include information sufficient to identify the claim involved (including date of service, healthcare Provider, claim amount (if applicable)) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;

ii. State the specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim;

iii. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Member's claim;

iv. Reference the specific Plan of Benefits provisions on which the determination is based;

v. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;

vi. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;

vii. If the reason for denial is based on a lack of Medical Necessity, Investigational or Experimental exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);

viii. Disclose any internal rule, guideline or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);

ix. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals;

x. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes; and,

xi. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.

b. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings associated with the Adverse Benefit Determination.

c. No decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.

d. The Member will also receive a notice if the claim is approved.

B. APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

1. Member has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

   a. An appeal must be in writing;

b. An appeal must be sent (via U.S. mail) to the address on the Member's Identification Card;

c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,

d. An appeal must include the Member's name, address, identification number and any other information, documentation or materials that support the Member's appeal.

2. The Member may submit written comments, documents or other information in support of the appeal and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3. The Member must raise all issues and grounds for appealing an Adverse Benefit Determination at every stage of the appeals process or such issues and grounds will be deemed permanently waived.

4. If the appealed claim involves an exercise of medical judgment, the claims administrator will consult with an appropriately qualified healthcare practitioner with training and experience in the relevant field of medicine. If a healthcare professional was consulted for the initial determination, a different healthcare professional will be consulted on the appeal.

5. The final decision on the appeal will be made within the time periods specified below:

a. Pre-Service Claim

The Corporation (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than thirty (30) days after receipt of the appeal.

b. Urgent Care Claim

The Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Corporation (on behalf of the Group Health Plan) will communicate with the Member by telephone or facsimile. The Corporation (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.

c. Post-Service Claim

The Corporation (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time but no later than sixty (60) days after receipt of the appeal.

d. Concurrent Care Claim

The Corporation (on behalf of the Group Health Plan) will decide the appeal of Concurrent Care claims within the time frames set forth in Article VIII(B)(5)(a-c) depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

6. Notice of Final Internal Appeals Determination

   a. If a Member's appeal is denied in whole or in part, the Member will receive notice of an Adverse Benefit Determination, in a culturally and linguistically appropriate manner, that will:

      i. Include information sufficient to identify the claim involved (including date of service, healthcare Provider, claim amount (if applicable)) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;

      ii. State specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim and a discussion of the decision;

      iii. Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;

      iv. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;

      v. Describe any voluntary appeal procedures offered by the Corporation (on behalf of the Group Health Plan) and the Member's right to obtain such information;

      vi. Disclose any internal rule, guideline or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);

      vii. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);

      viii. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals;

      ix. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act, to assist individuals with the internal claims and appeals and external review processes; and,

      x. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.

   b. The Member will also receive, free of charge, any new or additional evidence considered, relied upon or generated in connection with the claim. This evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination is received to give the Member a reasonable opportunity to respond prior to that date.

   c. If the Adverse Benefit Determination is based on a new or additional rationale, then the Member will be provided with the rationale, free of charge. The rationale will be provided as soon as possible and sufficiently in advance of the date of the Adverse Benefit Determination to give the Member a reasonable opportunity to respond prior to that date.

d. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings associated with the Adverse Benefit Determination.

e. No decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.

f. A Member's claim and appeals will be decided pursuant to a good faith interpretation of the Plan of Benefits, in the best interest of the Member, without taking into account either the amount of the Benefits that will be paid to the Member or the financial impact on the Group Health Plan.

g. The Member will also receive a notice if the claim on appeal is approved.

7. The Employer has retained the Corporation to assist the Employer in making the initial claims determination as well as determinations on appeal as the claims fiduciary. Accordingly, Employer has delegated to the Corporation discretionary authority to construe and interpret questions of related to claims for Benefits under the terms of the Group Health Plan. The Employer delegates to the Corporation the discretionary authority to make utilization review and precertification determinations for the purpose of making claim decisions under the Plan of Benefits and to interpret and construe the Plan of Benefits as necessary to make such determinations. It is understood and agreed that the Corporation is a fiduciary with respect to its exercise of such discretionary authority. In making its decision, the Corporation will rely on the Plan of Benefits, its internal procedures and will rely on eligibility data provided by the Employer. The Corporation will undertake the responsibility for providing the initial and appellate review and final determination of claims that have been denied in whole or in part in accordance with the rules set forth in applicable federal law and the regulations there under.

C. EXTERNAL REVIEW PROCEDURES

1. After a Member has completed the appeal process, a Member may be entitled to an additional, external review of the Member's claim at no cost to the Member. An external review may be used to reconsider the Member's claim if the Corporation has denied, either in whole or in part, the Member's claim. In order to qualify for external review, the claim must have been denied, reduced, or terminated because:

   a. It does not meet the requirements for Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness; or,

   b. It is an Investigational or Experimental service and it involves a life-threatening or seriously disabling condition.

2. After a Member has completed the appeal process (and an Adverse Benefit Determination has been made), such Member will be notified in writing of such Member's right to request an external review. The Member should file a request for external review within four (4) months of receiving the notice of the Corporation's decision on the Member's appeal. In order to receive an external review, the Member will be required to authorize the release of such Member's medical records (if needed in the review for the purpose of reaching a decision on Member's claim).

3. Within five (5) business days of the date of receipt of a Member's request for an external review, the Corporation will respond by either:

   a. Assigning the Member's request for an external review to an independent review organization and forwarding the Members records to such organization; or,

   b. Notifying the Member in writing that the Member's request does not meet the requirements for an external review and the reasons for the Corporation's decision.

4. The external review organization will take action on the Member's request for an external review within forty-five (45) days after it receives the request for external review from the Corporation.

5. Expedited external reviews are available if the Member's Provider certifies that the Member has a serious medical condition. A serious medical condition, as used in this Article VIII(C)(5), means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place the Member's health in serious jeopardy. If the Member may be held financially responsible for the treatment, a Member may request an expedited review of the Corporation's decision if the Corporation's denial of Benefits involves Emergency Services and the Member has not been discharged from the treating Hospital. The independent review organization must make its decision within seventy-two (72) hours after it receives the request for expedited review.

ARTICLE IX - GENERAL PROVISIONS

ADMINISTRATIVE SERVICES ONLY

The Corporation provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Group Health Plan is a self-funded health Plan and the Employer assumes all financial risk and obligation with respect to claims.

AMENDMENT

Upon thirty (30) days prior written notice, the Employer may unilaterally amend the Group Health Plan. Increases in the Benefits provided or decreases in the premium are effective without such prior notice. The Corporation has no responsibility to provide individual notices to each Member when an amendment to the Group Health Plan has been made.

AUTHORIZED REPRESENTATIVES

A Provider may be considered a Member's Authorized Representative without a specific designation by the Member when the Preauthorization request is for Urgent Care Claims. A Provider may be a Member's Authorized Representative with regard to non-Urgent Care Claims only when the Member gives the Corporation or the Provider a specific designation, in a format that is reasonably acceptable to the Group Health Plan to act as an Authorized Representative. If the Member has designated an Authorized Representative, all information and notifications will be directed to that representative unless the Member gives contrary directions.

THE BLUECARD PROGRAM

A. Inter-Plan Arrangements

BCBSF and its Designated Agent have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield

Association ("Association"). Whenever members access healthcare services outside the geographic area BCBSF's Designated Agent serves (i.e. South Carolina), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area BCBSF's Designated Agent serves (i.e. South Carolina), members obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. BCBSF remains responsible for fulfilling our contractual obligations to Employer. BCBSF's and/or its Designated Agent's payment practices in both instances are described below. For purposes of Inter-Plan Arrangements, BCBSF is a Host Plan for services provided within Florida.

This disclosure describes how claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. (Note that Dental Care Benefits, except when not paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by BCBSF and/or its Designated Agent to provide the specific service or services are not processed through Inter-Plan Arrangements.)

B. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when members access covered healthcare services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim – In General

   a. Member Liability Calculation

      Unless subject to a fixed dollar copayment, the calculation of the member liability on claims for covered healthcare services will be based on the lower of the participating provider's billed covered charges or the negotiated price made available to BCBSF and/or its Designated Agent by the Host Blue.

   b. Employer Liability Calculation

      The calculation of Employer liability on claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSF and/or its Designated Agent by the Host Blue (under the contract between the Host Blue and the provider). Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its participating healthcare provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Employer may be liable for the excess amount even when the member's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the provider, even when the contracted price is greater than the billed charge.

2. Claims Pricing

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's provider contracts. The negotiated price made available to BCBSF and/or its Designated Agent by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim specific basis, retrospective settlements and performance related bonuses or incentives; or

(iii) An average price. An average price is a percentage of billed covered charges in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price Employer pays on a specific claim and the actual amount the Host Blue pays to the provider. However, the BlueCard Program requires that the amount paid by the member and Employer is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future claim prices. As a result, the amounts charged to Employer will be adjusted in a following year, as necessary, to account for over- or underestimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Employer. If Employer terminates, you will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

3. BlueCard Program Fees and Compensation

Employer understands and agrees to reimburse BCBSF and/or its Designated Agent for certain fees and compensation which BCBSF is obligated under the BlueCard Program to pay to the Host Blues, to the Association and/or to vendors of BlueCard Program related services. The specific BlueCard Program fees and compensation that are charged to Employer are set forth in this Exhibit B. BlueCard Program Fees and compensation may be revised from time to time.
Only the BlueCard Program access fee and the BlueCard Administrative Expenses Allowance (AEA) fee may be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program related fees are included in the Base

Administrative Fees.

The access fee is charged by the Host Blue to BCBSF and/or its Designated Agent for making its applicable provider network available to Employer's members. The access fee will not apply if the provider does not participate in the applicable Host Blue's network. The access fee is charged on a per claim basis and is charged as a percentage of the discount/differential BCBSF and/or its Designated Agent receives from the applicable Host Blue subject to a maximum of $2,000 per claim. When charged BCBSF and/or its Designated Agent pass the access fee directly on to Employer.

Instances may occur in which the claim payment is zero or BCBSF and/or its Designated Agent pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, BCBSF and/or its Designated Agent will pay the Host Blue's access fee and pass it along directly to Employer as stated above even though Employer paid little or had no claim liability.

The AEA fee is a fixed per claim dollar amount charged by the Host Blue to BCBSF and/or its Designated Agent for administrative services that the Host Blue provides in processing claims for Employer's members. The dollar amount is normally based on the type of claim (e.g. institutional, professional, international, etc.) and can also be based on the size of your group enrollment. When charged, BCBSF and/or its Designated Agent pass the AEA fee directly on to Employer.

See the fee section of this Exhibit B for the BlueCard Program access fee and AEA fee and for BCBSF's Base Administrative Fee. The Base Administrative Fee includes all other fees relative to the BlueCard Program. These fees include the central financial agency fee, ITS transaction fee, toll free number fee, PPO provider directory fee and Blue Cross Blue Shield Global® Core Program Fees, if applicable.

A Base Administrative Fee encompasses fees BCBSF charges to Employer for administering Employer's benefit plan. They may include both local (within BCBSF's Designated Agent's service area, i.e. South Carolina) and Inter-Plan fees. For purposes of this Agreement they include the following BlueCard Program related fees other than the BlueCard Program access fee and AEA fee: namely central financial agency fee, ITS transaction fee, toll free number fee, PPO provider directory fee and Blue Cross Blue Shield Global® Core Program Fees, if applicable.

C. Negotiated Arrangements

With respect to one or more Host Plans, instead of using the BlueCard Program, BCBSF and/or its Designated Agent may process your member claims for covered healthcare services through Negotiated Arrangements. Negotiated Arrangements or Negotiated National Account Arrangements are agreements negotiated between a Home Licensee and one or more Host Licensees for any national account that is not delivered through the BlueCard Program.

In addition, if BCBSF and Employer have agreed that (a) Host Blue(s) shall make available (a) custom healthcare provider network(s) in connection with this Agreement, then the terms and conditions set forth in BCBSF's Negotiated Arrangement(s) for National Accounts with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of claims when members access such network(s). In negotiating such arrangement(s), BCBSF is not acting on behalf of or as an agent for Employer, Group Health Plan or Employer's members.

Member Liability Calculation

Member liability calculation will be based on the negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) that the Host Blue makes available to BCBSF and/or its Designated Agent and that allows Employer's members access to negotiated participation agreement networks of specified participating providers outside of BCBSF's Designated Agent's service area (i.e. South Carolina).

The amount the member pays for covered healthcare services under such arrangement at the point of service, if not a flat dollar copayment, will be calculated based on the "price" that the Host Blue passed to BCBSF and/or its Designated Agent and that allows Employer's members access to negotiated participation agreement networks of specified participating providers outside of BCBSF's Designated Agent's service area (i.e. South Carolina). The "price" may be the:

(i) Negotiated price/lower of either billed covered charges or negotiated price; or

(ii) Lower of either billed covered charges or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program).

Under certain circumstances, if BCBSF and/or its Designated Agent pay the healthcare provider amounts that are the responsibility of the member BCBSF and/or its Designated Agent may collect such amounts from the member.

In situations where participating agreements allow for bulk settlement reconciliations for Episode-Based Payment/Bundled Payments, BCBSF and/or its Designated Agent may include a factor for such settlement reconciliations as part of the fees BCBSF and/or its Designated Agent charges to Employer.

Fees and Compensation

Employer understands and agrees to reimburse BCBSF and/or its Designated Agent for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time. In addition, the participation agreement with the Host Blue may provide that BCBSF and/or its Designated Agent must pay an administrative and/or a network access fee to the Host Blue, and Employer further agrees to reimburse BCBSF and/or its Designated Agent for any such applicable administrative and/or network access fees. The specific fees and compensation that are charged to BCBSF and/or its Designated Agent under Negotiated Arrangements are set forth in this Exhibit B

D. Special Cases: Value-Based Programs

Value-Based Programs Definitions

Accountable Care Organization (ACO): A group of healthcare providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

Global Payment/Total Cost of Care: A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and prescription drugs.

Patient-Centered Medical Home (PCMH): A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility

for patient care and, when appropriate, arranges for care with other qualified physicians.

Shared Savings: A payment mechanism in which the provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

Value-Based Program (VBP): An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

Value-Based Programs Overview

Employer's members may access covered healthcare services from providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs under the BlueCard Program

Under Value-Based Programs, a Host Blue may pay providers for reaching agreed upon cost/quality goals in the following ways:

The Host Blue may pass these provider payments to BCBSF and/or its Designated Agent, which BCBSF and/or its Designated Agent will pass directly on to Employer as either an amount included in the price of the claim or an amount charged separately in addition to the claim.

When such amounts are included in the price of the claim, the claim may be billed using one of the following pricing methods, as determined by the Host Blue:

(i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the claim. These charges are passed to Employer via an enhanced provider fee schedule.

(ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the claim, they may be billed as follows:

- Per Member Per Month (PMPM) Billings: Per member per month billings for Value-Based Programs incentives/Shared Savings settlements to accounts are outside of the claim system. BCBSF and/or its Designated Agent will pass these Host Blue charges directly through to Employer as a separately identified amount on the group billings; or,
- Where Host Blues pass on the costs of Value-Based Programs to BCBSF and/or its Designated Agent as PMPM amounts not attached to specific claims, BCBSF and/or its Designated Agent may elect to pass these amounts to Employer as a claim amount.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM

billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.

- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PMPM price methods, described above, are calculated. If Employer terminates, you will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement.

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

Note: Members will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay providers under Value-Based Programs.

Care Coordinator Fees

Host Blues may also bill BCBSF and/or its Designated Agent for care coordinator fees for provider services which we will pass on to Employer as follows:

1. PMPM billings; or

2. Individual claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

As part of this Agreement, BCBSF and Employer will not impose member cost sharing for care coordinator fees.

Value-Based Programs under Negotiated Arrangements

If BCBSF has entered into a Negotiated Arrangement/ with a Host Blue to provide Value-Based

Programs to Employer's members BCBSF and/or its Designated Agent will follow the same procedures for Value-Based Programs administration and care coordination fees as noted in the BlueCard Program section.

E. Return of Overpayments

Recoveries from a Host Blue or its participating and nonparticipating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to BCBSF and/or its Designated Agent they will be credited to Employer. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to Employer as a percentage of the recovery.

F. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BCBSF and/or its Designated Agent will disclose any such surcharge, tax or other fee to Employer, which will be Employer's liability.

G. Nonparticipating Providers Outside BCBSF's Designated Agent's Service Area (i.e. South Carolina)

1. Member Liability Calculation

a. In General

When covered healthcare services are provided outside of BCBSF's Designated Agent's service area (i.e. South Carolina) by nonparticipating providers, the amount(s) a member pays for such services will be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment BCBSF and/or its Designated Agent will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

b. Exceptions

In some exception cases, at Employer's direction, BCBSF and/or its Designated Agent may pay claims from nonparticipating healthcare providers outside of BCBSF's Designated Agent's service area (i.e., South Carolina) based on the provider's billed charge. This may occur in situations where a member did not have reasonable access to a participating provider, as determined by BCBSF and/or its Designated Agent in BCBSF's and/or its Designated Agent's sole and absolute discretion, or by applicable state law. In other exception cases, at Employer's direction, BCBSF and/or its Designated Agent may pay such claims based on the payment BCBSF and/ or its Designated Agent would make if BCBSF and/or its Designated Agent were paying a nonparticipating provider inside BCBSF's Designated Agent's service area (i.e. South Carolina), as described elsewhere in this Agreement. This may occur where the Host Blue's corresponding payment would be more than BCBSF's Designated Agent's in-service area nonparticipating provider payment. BCBSF and/or its Designated Agent may choose to negotiate a payment with such a provider on an exception basis.

The member may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and the payment BCBSF and/or its Designated Agent will make for the covered services as set forth in this paragraph.

2. Fees and Compensation

Employer understands and agrees to reimburse BCBSF and/or its Designated Agent for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement related services. The specific fees and compensation that are charged to Employer are set forth in this Exhibit B, if applicable. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time.

H. Blue Cross Blue Shield Global® Core Program

1. General Information

If members are outside the United States, (the Commonwealth of Puerto Rico and the U.S. Virgin Islands) (hereinafter: "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing covered healthcare services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when members receive care from providers outside the BlueCard service area, the members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

- Inpatient Services

  In most cases, if members contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit member claims to the Blue Cross Blue Shield Global Core Service Center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered healthcare services. Members must contact BCBSF and/or its Designated Agent to obtain precertification for non-emergency inpatient services.

- Outpatient Services

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered healthcare services.

- Submitting a Blue Cross Blue Shield Global Core Claim

  When members pay for covered healthcare services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, members should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate claims processing. The claim form is available from BCBSF and/or its Designated Agent, the

Blue Cross Blue Shield Global Core Service Center, or online at www.bluecardworldwide.com. If members need assistance with their claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

2. Blue Cross Blue Shield Global Core Program-Related Fees

Employer understands and agrees to reimburse BCBSF and/or its Designated Agent for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement related services. The specific fees and compensation that are charged to Employer under the Blue Cross Blue Shield Global Core Program are set forth in this Exhibit B, if applicable. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time.

CLERICAL ERRORS

Clerical errors by the Corporation or the Employer will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

DISCLOSURE OF PHI TO PLAN SPONSOR

The Group Health Plan will disclose (or will require the Corporation to disclose) Member's PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Group Health Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Plan Sponsor will be subject to and consistent with the provisions of paragraphs A and B of this section.

A. Restrictions on the Plan Sponsor's Use and Disclosure of PHI.

1. The Plan Sponsor will neither use nor further disclose Member's PHI, except as permitted or required by the Group Health Plan documents, as amended, or required by law.

2. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Member PHI agrees to the restrictions and conditions of the Plan of Benefits with respect to Member's PHI.

3. The Plan Sponsor will not use or disclose Member PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

4. The Plan Sponsor will report to the Group Health Plan any use or disclosure of Member PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

5. The Plan Sponsor will make PHI available to the Member who is the subject of the information in accordance with HIPAA.

6. The Plan Sponsor will make Member PHI available for amendment and will, on notice, amend Member PHI in accordance with HIPAA.

7. The Plan Sponsor will track disclosures it may make of Member PHI so that it can make available the information required for the Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.

8. The Plan Sponsor will make its internal practices, books and records relating to its use and disclosure of Member PHI available to the Group Health Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.

9. The Plan Sponsor will, if feasible, return or destroy all Member PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Member who is the subject of the PHI, when the Member's PHI is no longer needed for the Group Health Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Plan Sponsor will limit the use or disclosure of any Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

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

11. The Plan Sponsor will ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides ePHI (that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Group Health Plan) agrees to implement reasonable and appropriate security measures to protect this information.

12. The Plan Sponsor shall report any security incident of which it becomes aware to the Group Health Plan as provided below.

    a. In determining how and how often the Plan Sponsor shall report security incidents to the Group Health Plan, both the Plan Sponsor and the Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both the Plan Sponsor and the Group Health Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do not result in unauthorized access, use, disclosure, modification or destruction of ePHI or interference with an information system:

        i. Pings on a party's firewall;

        ii. Port scans;

        iii. Attempts to log on to a system or enter a database with an invalid password or username;

        iv. Denial-of-service attacks that do not result in a server being taken offline; and,

        v. Malware (e.g., worms, viruses).

b. The Plan Sponsor shall, however, separately report to the Group Health Plan any successful unauthorized access, use, disclosure, modification or destruction of the Group Health Plan's ePHI of which the Plan Sponsor becomes aware if such security incident either (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of the Group Health Plan's ePHI; or (c) results in a breach of availability of the Group Health Plan's ePHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after the Plan Sponsor becomes aware of the impact of such security incident upon the Group Health Plan's ePHI.

B. Adequate Separation between the Plan Sponsor and the Group Health Plan.

1. Only Employees or other workforce members under the control of the Plan Sponsor (''Employees'') who, in the normal course of their duties, assist in the administration of Employee Benefits or the Group Health Plan or the Group Health Plan finances or other classes of Employees as designated in writing by the Plan Sponsor, may be given access to Member PHI received from the Group Health Plan or a business associate servicing the Group Health Plan.

2. These Employees will have access to Member PHI only to perform the Group Health Plan administration functions that the Plan Sponsor provides for the Group Health Plan.

3. These Employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Member PHI in breach or violation of or noncompliance with the provisions of this section. The Plan Sponsor will promptly report such breach, violation or noncompliance to the Group Health Plan and will cooperate with the Group Health Plan to correct the breach, violation or noncompliance to impose appropriate disciplinary action or sanctions on each Employee or other workforce member causing the breach, violation or noncompliance and to mitigate any deleterious effect of the breach, violation or noncompliance on any Member, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

4. The Plan Sponsor will ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.

The Plan Sponsor certifies that the Group Health Plan contains and that the Plan Sponsor agrees to the provisions outlined above.

EMPLOYER IS AGENT OF MEMBERS

By accepting Benefits, a Member agrees that the Employer is the Member's agent for all purposes of any notice under the Group Health Plan and Plan of Benefits. The Member further agrees that notifications received from, or given to, the Employer by the Corporation are notification to the Employees except for any notice required by law to be given to the Members by the Corporation.

GOVERNING LAW

The Group Health Plan and Plan of Benefits (including the Schedule of Benefits) are governed by and subject to applicable federal law. If and to the extent that federal law does not apply, the Group Health Plan and Plan of Benefits are governed by and subject to the laws of the State of Florida. If federal law conflicts with any state law, then such federal law shall govern. If any provision of the Group Health Plan or Plan of Benefits conflicts with such law, the Group Health Plan and Plan of Benefits shall automatically be amended solely as required to comply with such state or federal law.

IDENTIFICATION CARD

A Member must present his or her Identification Card prior to receiving Benefits.

Identification Cards are for identification only. Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Member whose premium has been paid. Any person receiving Covered Expenses to which the person is not entitled will be responsible for the charges.

INFORMATION AND RECORDS

The Corporation and the Employer are entitled to obtain such medical and Hospital records as may reasonably be required from any Provider incident to the treatment, payment and healthcare operations for the administration of the Benefits hereunder and the attending Provider's certification as to the Medical Necessity for care or treatment.

LEGAL ACTIONS

No Member may bring an action at law or in equity to recover under the Group Health Plan or Plan of Benefits until such Member has exhausted the appeal process as set forth in Article VIII of the Plan of Benefits. No such action may be brought after the expiration of any applicable period prescribed by law.

NEGLIGENCE OR MALPRACTICE

The Corporation and Employer do not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Member by a Provider is rendered or supplied by such Provider and not by the Corporation or the Employer. The Corporation and Employer are not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in rendering such medical treatment, service, Medical Supply or medication.

NOTICES

Except as otherwise provided in this Plan of Benefits, any notice under this Plan of Benefits may be given by United States registered or certified mail, postage paid, return receipt requested or nationally recognized carrier and addressed:

1. To the Corporation:

   BlueCross BlueShield
   P.O. Box 100121
   Columbia, South Carolina 29202

2. To a Member: To the last known name and address listed for the Employee related to such Member on the membership application. Members are responsible for notifying the Corporation of any name or address changes within thirty-one (31) days of the change.

3. To the Employer: To the name and address last given to the Corporation. The Employer is responsible for notifying the Corporation and Members of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF RIGHTS

On occasion, the Corporation (on behalf of the Group Health Plan) or the Employer may, at their discretion, choose not to enforce all of the terms and conditions of the Group Health Plan or Plan of Benefits. Such a decision does not mean the Group Health Plan or Employer waives or gives up any rights under the Group Health Plan or Plan of Benefits in the future.

OTHER INSURANCE

Each Member must provide the Group Health Plan (and its designee, including the Corporation) and Employer with information regarding all other health insurance coverage to which such Member is entitled.

PAYMENT OF CLAIMS

A Member is expressly prohibited from assigning any right to payment of or related to Benefits. The Group Health Plan may pay all Benefits directly to the Member upon receipt of due proof of loss when a Non-Participating Provider renders services. When payment is made directly to the Member, the Member is responsible for any payment to the Provider. Where a Member has received Benefits from a Participating Provider, the Group Health Plan will pay Benefits directly to such Participating Provider.

PHYSICAL EXAMINATION

The Group Health Plan has the right to have examined, at their own expense, a Member whose injury or sickness is the basis of a claim (whether a Pre-Service Claim, Post-Service Claim, Concurrent Care claim or Urgent Care Claim). Such physical examination may be made as often as the Group Health Plan (through its designee, including the Corporation) may reasonably require while such claim for Benefits or request for Preauthorization is pending.

REPLACEMENT COVERAGE

If the Group Health Plan replaced the Employer's prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered under the Plan of Benefits Effective Date of the Group Health Plan, provided such persons are enrolled.

INDEX

This index contains instances of the use of defined terms in the Group Health Plan. This index does not include Benefits or excluded items.

ABA 1, 15, 28
ACA 1, 22, 26
Admission. 1, 3, 4, 10, 14, 15, 19, 20, 24, 27, 31, 33
Adverse Benefit Determination 1, 52, 53, 54, 55, 56
Allowable Charge 1, 2, 3, 14, 25, 26
Alternate Recipient.....1, 7, 12, 43, 44
Ambulatory Surgical Center 1, 22
Authorized Representative.....1, 3, 4, 10, 57
Autism Spectrum Disorder 2, 15, 28
Behavioral Health Provider 2, 11, 20
Behavioral Health Services.....2, 3, 11
Benefit Year 2, 9, 14, 18, 22, 23, 38
Benefit Year Deductible 1, 2, 3, 13, 14, 24
Benefits 1, 2, 3, 4, 7, 9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 31, 32, 34, 35, 36, 37, 38, 39, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 55, 56, 57, 66, 68, 69, 70
Benefits Checklist.....2, 6, 9
Billed Charges.....1, 2
BlueCard Program 2
Clinical Trial.....2, 17
COBRA..... 2, 38, 39, 40, 41, 42
COBRA Administrator 2, 40, 41
Coinsurance 1, 2, 3, 13, 14
Companion Benefit Alternatives (CBA).....3, 8
Concurrent Care.....3, 51, 52, 54, 70
Congenital Disease 3
Congenital Disorder 3
Contact Lenses 30
Continued Stay Review.....3, 14, 15, 19, 24
Contracting Provider 22, 50, 70
Copayment.....1, 3, 13, 14
Corporation 1, 2, 3, 4, 5, 6, 8, 10, 11, 14, 15, 16, 18, 21, 23, 24, 30, 31, 32, 35, 36, 37, 46, 47, 48, 49, 50, 51, 52, 54, 55, 56, 57, 66, 68, 69, 70
Covered Expenses... 2, 3, 16, 32, 37, 38, 42, 43, 69
Credit.....6
Custodial Care 3, 12, 29
Durable Medical Equipment.....3, 4, 18, 22
Emergency Admission Review...4, 14, 15, 19, 24
Emergency Medical Condition ...4, 10, 15, 16, 18
Emergency Services.....1, 4, 57
Employee ..1, 2, 4, 5, 7, 8, 12, 36, 37, 39, 40, 41, 42, 43, 44, 66, 68, 69
Employer...2, 4, 9, 12, 35, 38, 39, 40, 41, 42, 43, 44, 49, 50, 54, 56, 57, 66, 68, 69, 70
Employer's Effective Date.....4, 34
ERISA 4, 36, 43, 44, 53, 55
Group Health Plan ..2, 3, 4, 6, 7, 8, 9, 14, 15, 17, 18, 19, 20, 21, 23, 24, 25, 26, 31, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 46, 47, 48, 49, 50, 51, 52, 54, 55, 56, 57, 66, 68, 69, 70
HIPAA 4, 10, 66
Home Health Agency.....4, 10
Home Health Care 4, 19, 22
Hospice Care 4, 19
Hospital .1, 4, 5, 6, 11, 13, 16, 18, 19, 20, 21, 22, 26, 38, 57, 69
Identification Card.....5, 15, 24, 54, 69
Incapacitated Dependent.....5, 30
Investigational or Experimental...1, 5, 31, 53, 55, 56
Legal Intoxication 5
Legally Intoxicated 5, 31
Long-Term Acute Care Hospital 5, 6, 19, 24
Maximum Payment 1, 6
Medical Child Support Order 1, 7, 12, 43
Medical Necessity...8, 10, 14, 22, 23, 31, 53, 55, 56, 69
Medical Supplies.2, 7, 16, 18, 19, 21, 24, 28, 29, 30, 31, 34, 69
Medically Necessary.1, 2, 3, 7, 8, 14, 15, 19, 20, 24, 26, 32, 38
Member.....1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 31, 33, 34, 35, 36, 38, 39, 40, 41, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 66, 67, 68, 69, 70
Mental Health Services.....2, 8, 20, 21
Natural Teeth 9, 18
Non-Participating Provider.....9
Orthopedic Device 4, 9, 21
Orthotic Device 4, 9, 22
Out-of-Pocket Maximum 2, 9, 24
Over-the-Counter Drug 9, 10, 32
Participating Provider.....6, 9, 50
PHI 10, 66, 67, 68

Plan 1, 4, 9, 10, 13, 18, 28, 33, 35, 36, 37, 38, 39, 42, 44, 45, 46, 47, 48, 49, 50, 56
Plan Administrator 9, 39, 43
Plan of Benefits 1, 2, 3, 4, 7, 8, 9, 10, 12, 13, 14, 15, 22, 29, 34, 35, 42, 43, 44, 49, 53, 55, 56, 66, 68
Plan of Benefits Effective Date 9, 70
Plan Sponsor.....6, 9, 39, 66, 68
Post-Service Claim.....9, 51, 52, 54, 70
Preadmission Review..... 10, 14, 15, 19, 24
Preauthorization3, 10, 14, 15, 18, 21, 23, 24, 27, 32, 33, 57, 70
Preauthorized..... 2, 3, 10, 16, 29, 30, 34
Prescription Drug 10, 13, 28, 32, 33
Prescription Drug List.....10, 32
Prescription Drug Preauthorization Program ...10
Pre-Service Claim 9, 10, 51, 54, 70
Primary Plan..... 10, 13, 35, 36, 37, 38
Private Duty Nursing 10, 22
Prosthetic Device 4, 10, 17, 23
Provider 1, 2, 3, 5, 7, 8, 9, 10, 11, 13, 14, 17, 18, 20, 21, 23, 26, 27, 30, 32, 33, 34, 35, 39, 49, 50, 52, 55, 57, 69, 70
Provider Agreement 9, 11
Provider Services 11, 12, 23, 31
Qualified Medical Child Support Order12, 42, 43, 44
Qualifying Event 12, 39, 40, 41
Rehabilitation Facility 12
Residential Treatment Center 12, 24
Schedule of Benefits ...2, 3, 9, 13, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 68
Second Surgical Opinion 13
Secondary Plan.....13, 35, 36, 37, 38
Skilled Nursing Facility.....1, 11, 13, 20, 24
Special Care Unit 13, 19, 24
Specialist.....13
Specialty Drugs.....13
Substance Use Disorder 13, 31
Substance Use Disorder Services 2, 8, 13, 20, 25, 31
Surgical Services 13, 17, 20, 22, 25, 26
Telehealth 13, 26
Telemedicine.....13, 26
Urgent Care Claim 14, 51, 52, 54, 57, 70
USERRA 14, 42
VBP 27
Well Baby Care 14
Well Child Care 14

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'áąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshįį bí na'idołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)