

The Johns Hopkins University Retiree Health Plan

Summary of Benefits

Effective April 1, 2024

Summary of Benefits

For

The Johns Hopkins University Retiree Health Plan

Administered By

CareFirst Administrators (CFA®)

An independent licensee of the Blue Cross and Blue Shield Association

The Johns Hopkins University Retiree Health Plan (hereafter called the "Plan") is a self-funded plan organized and qualified under, and governed by, the provisions of the Employee Retirement Income Security Act of 1974, 29 USC 1001 et seq. To the extent that this health care benefits plan is completely or partially self-funded, CFA provides administrative services only and does not assume any financial risk or obligation with respect to health care benefit claims for the self-insured portion of the Plan.

The Plan is subject to all the terms, provisions and limitations stated on the following pages. This revised Plan is effective as of 12:01 A.M. Eastern Time on April 1, 2024.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Summary of Benefits to be executed.

The Johns Hopkins University



Signature

Joel Searfoss

Name

Name

Director of Benefits Compliance and Operations

Title

May 7, 2024

Date

ON BEHALF OF:

**The Johns Hopkins University Retiree Health
Plan,**
effective April 1, 2024

TABLE OF CONTENTS

INTRODUCTION	1
PLAN INFORMATION	2
CHAPTER 1	5
DEFINITIONS	5
CHAPTER 2	16
MEDICAL BENEFITS	16
COVERED SERVICES.....	59
LIMITATIONS AND EXCLUSIONS.....	86
CHAPTER 3	90
PRESCRIPTION DRUG BENEFITS	90
CHAPTER 4	97
UTILIZATION MANAGEMENT	97
CHAPTER 5	103
GENERAL INFORMATION	103
COORDINATION OF BENEFITS.....	103
CLAIM PROVISIONS	106
CLAIM FILING INSTRUCTIONS	109
CLAIMS AND APPEALS PROCESS	110
INTER-PLAN ARRANGEMENTS	122
FEDERAL LAWS.....	129
MISCELLANEOUS PROVISIONS.....	138

INTRODUCTION

The Johns Hopkins University Retiree Health Plan (hereafter called the "Plan") is a self-funded group health plan organized and qualified under, and governed by, the provisions of the Employee Retirement Income Security Act of 1974, 29 USC 1001 et seq., and is designed to assist you and your family with the payment of health care expenses.

This booklet is a Summary of Benefits. Using non-technical language, it describes your benefits under the Plan and will answer most of your questions. It contains a Schedule of Benefits, descriptions of the benefits listed in the Schedule, a list of the limitations of the Plan, definitions, instructions for filing claims, and procedures on what to do if you have any problems with a claim. In order to fully understand your benefits and to avoid confusion, you and your family should read this booklet carefully and completely.

The benefits and provisions of the Plan have been described as carefully as possible. A Table of Contents has been included to help you find the answers to your questions quickly. No one, including CareFirst Administrators (CFA), the medical claims administrator, can orally modify any Plan benefits or limitations.

Your Plan includes Utilization Management provisions. If you or any family member are going to be or are admitted to the hospital or receive certain outpatient procedures or services, you must contact the Utilization Management Vendor. Refer to Chapter 4 for additional information.

If you have any questions, contact the Claims Administrator, CFA. CFA handles the day-to-day business of the Plan and will be glad to answer your questions. Their telephone number is 877-889-2478.

Note Regarding HIPAA Privacy:

CFA complies with the privacy requirements outlined in the Health Insurance Portability and Accountability Act, otherwise known as HIPAA. The HIPAA Privacy Regulations are designed to provide protection against the unauthorized use and disclosure of a patient's health information.

If you call with a question about a Participant's claim, CFA is required to confirm that the caller can identify several key pieces of information about the claimant. In addition to the Participant's name, the caller will be required to provide three (3) of the following forms of identity:

- ID number
- Participant's date of birth
- Participant's address
- Participant's phone number
- Participant's zip code

Under certain circumstances, a completed Personal Representative or Authorization form will be required for an adult Participant. Adult Participants include the Employee, spouse, and dependent children age 18 and over.

PLAN INFORMATION

Name of Plan: The Johns Hopkins University Retiree Health Plan

Plan Sponsor: The Johns Hopkins University
1101 E. 33rd Street
Baltimore, MD 21218
Phone: 410-516-2000

Plan Sponsor ID No. (EIN): 52-0595110

**Plan Administrator
(Named Fiduciary):** The Johns Hopkins University
1101 E. 33rd Street
Baltimore, MD 21218
Phone: 410-516-2000

Source of Funding: Self-Funded

Applicable Law: ERISA

Plan Status: Non-Grandfathered

Plan Year: April 1 through March 31

Plan Number: 501

Plan Type: Medical
Prescription Drug

Claims Administrator: CFA
P.O. Box 981608
El Paso, Texas 79998

**Prescription Drug Claims
Administrator:** Capital Rx
228 Park Avenue S. Suite 87234
New York, NY 10003
Phone: 1-844-306-4674

Participating Employer(s): The Johns Hopkins University

Agent for Service of Process: The Johns Hopkins University
Plan Administrator
1101 E. 33rd Street
Baltimore, MD 21218
Phone: 410-516-2000

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

LEGAL ENTITY; SERVICE OF PROCESS - The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

APPLICABLE LAW - This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

INTERPRETATION OF THE PLAN – In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers to make determinations, consistent with the terms of the Plan. In making such interpretations and determinations, the Plan Administrator shall take into account the interpretation of the provisions and terms of the plan by the plan's reinsurance carrier and any other relevant information. Any and all such decisions and determinations made by the Plan shall be final and binding upon all parties.

IMPORTANT UPDATES REGARDING COVID-19 RELIEF – TOLLING OF CERTAIN PLAN DEADLINES - In accordance with 85 FR 26351, "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak," notwithstanding any existing Plan language to the contrary, the Plan will disregard the period from March 1, 2020 until sixty (60) days after (1) the end of the National Emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 5121 *et seq.* or (2) such other date announced by the Departments of Treasury and/or Labor, for purposes of determining the following periods and dates:

1. The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA section 701(f) and Internal Revenue Code section 9801(f);
2. The 60-day election period for COBRA continuation coverage under ERISA section 605 and Internal Revenue Code section 4980B(f)(5);
3. The date for making COBRA premium payments pursuant to ERISA section 602(2)(C) and (3) and Internal Revenue Code section 4980B(f)(2)(B)(iii) and (C);
4. The date for individuals to notify the Plan of a qualifying event or determination of disability under ERISA section 606(a)(3) and Internal Revenue Code section 4980B(f)(6)(C);
5. The date within which individuals may file a benefit claim under the Plan's claims procedure pursuant to 29 CFR 2560.503-1;
6. The date within which Claimants may file an appeal of an Adverse Benefit Determination under the Plan's claims procedure pursuant to 29 CFR 2560.503-1(h);
7. The date within which Claimants may file a request for an external review after receipt of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination pursuant to 29 CFR 2590.715-2719(d)(2)(i) and 26 CFR 54.9815-2719(d)(2)(i), if applicable; and
8. The date within which a Claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to 29 CFR 2590.715-2719(d)(2)(ii) and 26 CFR 54.9815-2719(d)(2)(ii), if applicable.

This period may also be disregarded in determining the applicable date for the Plan's duty to provide a COBRA election notice under ERISA section 606(c) and Internal Revenue Code section 4980B(f)(6)(D), however, note that the Plan intends to continue to follow all established COBRA parameters.

In no instance will the duration of an extension granted under this section exceed one calendar year.

CHAPTER 1

DEFINITIONS

Adverse Benefit Determination - A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on a determination of a Claimant's eligibility to participate in the Plan. An Adverse Benefit Determination includes determinations based on utilization review, Experimental or Investigational exclusions, and Medically Necessity, in addition to any rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time. A rescission means a cancellation or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required contributions toward the cost of coverage.

Air Ambulance Service - Medical transport of Participants by a rotary wing air ambulance, as defined in 42 C.F.R. 414.605, or fixed wing air ambulance, as defined in 42 C.F.R. 414.605.

All-Payer Model Agreement - An agreement between the Centers for Medicare & Medicaid Services (CMS) and a state to test and operate systems of all-payer payment reform for the medical care of residents of the particular state, under the authority granted under section 1115A the Social Security Act.

Allowed Benefit – An amount, as follows:

1. In-Network Provider: For a health care provider that is an In-Network Provider, the Allowed Benefit for a covered service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date that the service is rendered. The benefit is payable to the health care provider and is accepted as payment in full, except for any applicable Participant payment amounts, as stated in the Schedule of Benefits.
2. Out-of-Network Provider:
 - a. For Emergency Services, the Allowed Benefit for a covered service is the Recognized Amount. The benefit is payable to the Out-of-Network Provider. Additionally, the Participant is responsible for any applicable Participant payment amounts, as stated in the Schedule of Benefits.
 - b. For non-emergency services performed by Out-of-Network Providers at preferred health care facilities (including Ancillary Services and services for unforeseen urgent medical needs), the Allowed Benefit for a covered service is the Recognized Amount. The benefit is payable to the Out-of-Network Provider. Additionally, the Participant is responsible for any applicable Participant payment amounts, as stated in the Schedule of Benefits.
 - c. For Out-of-Network Provider of Air Ambulance Services, the Allowed Benefit is the lesser of the provider's actual charge or the Qualifying Payment Amount. The benefit is payable to the Out-of-Network Provider. Additionally, the Participant is responsible for any applicable Participant payment amounts, as stated in the Schedule of Benefits.
 - d. For all other covered services provided by:

- 1) A health care practitioner that is an Out-of-Network Provider, the Allowed Benefit for a covered service is based upon the lesser of the provider's actual charge or established fee schedule which, in some cases, will be a rate specified by applicable law. The benefit is payable to the Participant or to the health care practitioner, at the discretion of CareFirst. If CareFirst pays the Participant, it is the Participant's responsibility to pay the health care practitioner. Additionally, the Participant is responsible for any applicable Participant payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the health care practitioner's actual charge.
- 2) A hospital or health care facility that is an Out-of-Network Provider, the Allowed Benefit for a covered service is based upon the lower of the provider's actual charge or established fee schedule, which, in some cases, will be a rate specified by applicable law. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Participant payment amounts, as stated in the Schedule of Benefits. The benefit is payable to the Participant or to the hospital or health care facility, at the discretion of CareFirst. Benefit payments to United States Department of Defense and United States Department of Veteran Affairs providers will be made directly to the provider. If CareFirst pays the Participant, it is the Participant's responsibility to pay the hospital or health care facility. Additionally, the Participant is responsible for any applicable Participant payment amounts, as stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the hospital or health care facility's actual charge.
3. Outside of the Service Area, for a health care provider that has contracted with a local Blue Cross and/or Blue Shield Licensee (not CareFirst BlueCross BlueShield), the Allowed Benefit is calculated as stated in the Inter-Plan Arrangements Disclosure section of this document.

Ambulatory Surgical Facility - A licensed or certified institution that:

- a. Has permanent operating rooms and a recovery room, and all necessary equipment for use before, during, and after surgery;
- b. Is operated under the supervision of a Licensed Physician with a medical staff including Registered Nurses (RNs) available for care in an operating or recovery room; and
- c. Is other than a private office or clinic of one or more Physicians.

Ancillary Services - Facility services that may be rendered on an inpatient and/or outpatient basis. These services include, but are not limited to:

1. Items and services furnished by an Out-of-Network Provider in an in-network facility related to emergency medicine, anesthesiology, pathology, radiology, and neonatology.
2. Items and services provided by health care practitioners.
3. Diagnostic services, including radiology and laboratory services.

4. Items and services provided by an Out-of-Network Provider if there is no In-Network Provider who can provide the services to the Participant within the health care facility.
5. Other facility-based services like operating room services, incremental nursing services, blood administration and handling, pharmaceutical services, durable medical equipment and medical supplies.

Ancillary Services do not include room and board services billed by a facility for inpatient care.

Applied Behavior Analysis (ABA) – The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. ABA services include but are not limited to, mental health and behavioral health services, and rehabilitative therapy services.

Authorized Representative – For purposes of the Notice and Consent requirements of Note #2 of the Schedule of Benefits, an individual authorized by law to provide consent on behalf of the Participant, provided that the individual is not a health care provider affiliated with the health care facility or an Employee of the health care facility, unless the health care provider or Employee is a family member of the Participant.

Calendar Year - The 12-month period from January 1 through December 31.

CareFirst – CareFirst of Maryland, Inc., doing business as CareFirst BlueCross BlueShield.

CareFirst Administrators (CFA) - The Claims Administrator, which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims. CFA is an independent licensee of the Blue Cross and Blue Shield Association.

Claims Administrator - The person/organization providing consulting services to the Employer in connection with the operation of this Plan and performing such other functions, including processing and payment of claims, as may be delegated to it. The Claims Administrator is CareFirst Administrators (CFA).

Confinement - The period of time a patient spends as an inpatient in an approved facility. A confinement separated by 7 days or less is considered one confinement.

Custodial Care - The care provided primarily for maintenance of the patient. Custodial Care is designed essentially to assist the individual in meeting the activities of daily living and is not provided primarily for its therapeutic value in the treatment of an illness, accidental injury or condition. Custodial care includes, but is not limited to, helping in walking, bathing, dressing, feeding, or preparation of special diets.

Effective Date - The date on which coverage for an eligible Employee or an eligible Dependent begins.

Electronic Protected Health Information (EPHI) - The term "Electronic Protected Health Information" has the meaning set forth in 45 CFR § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

Emergency Medical Condition - A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 individual (or, with respect to a pregnant woman, the health of the woman 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 - With respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a hospital, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition;
2. Any such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the Participant, regardless of the department of the hospital in which such further examination or treatment is furnished to the Participant. The term “to stabilize” with respect to an Emergency Medical Condition, means to provide such medical treatment of the Emergency Medical Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the Participant from a facility; and
3. Post-stabilization services (i.e., services provided after the Participant has been stabilized, as part of outpatient observation, or an inpatient or outpatient stay related to the Emergency Services provided, as described above) as described in the Covered Services section.

Employer - The employer is The Johns Hopkins University.

Experimental/Investigational - A service or supply that is in the development state and in the process of human or animal testing (except for Clinical Trials – Patient Costs coverage, as stated in the Covered Services section of this document). Services or supplies that **not** meet all five (5) of the following criteria are deemed to be Experimental/Investigational for purposes of coverage under the Plan:

1. The Technology* must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;
3. The Technology must improve the net health outcome;
4. The Technology must be as beneficial as any established alternatives; and

5. The improvement must be attainable outside the Investigational settings.

*Technology includes drugs, devices, processes, systems, or techniques.

However, a service or supply will not be considered experimental or investigational if the Plan determines that:

- a. The disease can be expected to cause death within one year, in the absence of effective treatment; and
- b. The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination the Plan will take into account the results of a review of a panel of independent medical professionals.

This exception also applies with respect to drugs that:

- a. Have been granted treatment investigational new drug (IND) or Group/treatment IND status; or
- b. Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, if the Plan determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

Extended Care Facility - An institution operated pursuant to law and primarily engaged in providing room and board, together with 24-hour-a-day nursing service as needed to provide adequate medical care for persons convalescing from accident or illness and providing services under the supervision of a Physician or a Registered Nurse devoting full-time to such supervision. An Extended Care Facility must maintain adequate medical records and have available the services of a Physician under an established agreement if not supervised by a Physician. In no event shall such term include any institution which is:

- a. A Hospital;
- b. Primarily for the care of mental illness, drug addiction, or alcoholism; or
- c. Primarily engaged in providing domiciliary care, custodial care, educational care, or care for the aged.

Fertility Awareness-Based Methods – Means methods of identifying times of fertility and infertility by an individual to avoid pregnancy including:

1. Cervical mucus methods;
2. Symptom-thermal or symptom-hormonal methods;
3. The standard days method; and,
4. The lactational amenorrhea method.

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

Final Internal Adverse Benefit Determination - An Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Home Health Care - Care rendered to Participants who require active and skilled medical care at home. Home Health Care includes any array of professional, technical, and health-related services usually provided by hospitals to inpatients.

Home Health Care Provider - A Hospital, skilled nursing facility, local or state governmental health department, community Home Health Care agency, or other health organization. A Home Health Care Provider must be licensed by the state or certified by the U.S. Health Care Financing Administration as a provider of Home Health Care services.

Hospice Care - The Provider-directed professional, technical, and related medical, palliative, and personal care services provided under a Hospice Care Program.

Hospice Care Program - A coordinated interdisciplinary program for meeting the special physical, psychological, and social needs of dying individuals and their immediate families; which provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness to Participants who have no reasonable prospect of a cure and, as estimated by a Physician, have a life expectancy of less than 6 months; and which provides bereavement counseling to the immediate families of such Participant.

Hospice Provider - Any Hospital, Home Health Care agency, Hospice, or other facility or unit of such facility, that is licensed or certified (by the state in which services are rendered) to provide Hospice Care.

Hospital - A Licensed Provider, accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program, that is an acute-care institution primarily engaged in providing diagnostic and therapeutic services for surgical or medical treatment by or under the supervision of Physicians and that provides 24-hour-a-day nursing services. An institution specializing in the care and treatment of a mental illness, which would qualify as a hospital except that it lacks organized facilities on its premises for major surgery, shall nevertheless be deemed a hospital.

Host Blue – An on-site Blue Cross and/or Blue Shield Licensee providing benefits for covered services to a Participant outside the CFA service area.

Illness - Sickness or disease, including mental infirmity, which requires treatment by a Physician. A recurrent illness shall be considered the same illness. Concurrent illnesses shall be deemed the same illness unless such illnesses are totally unrelated.

In-Network Provider – A Licensed Provider that contracts with CareFirst to be paid directly for rendering covered services to Participants, or a Participating Provider.

Infertility - Disease or condition that results in the abnormal function of the reproductive system such that a person is not able to conceive or produce conception.

Injury - A condition caused by accidental means which results in damage to the Participant's body from an external force. All injuries sustained by a Participant in connection with an accident shall be considered one injury.

Intensive Outpatient Services - Intensive outpatient programs are defined as having the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family

group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured “crisis intervention programs,” “psychiatric or psychosocial rehabilitation,” and some “day treatment.”

Legend Drug - A pharmaceutical product that cannot be obtained legally without a physician’s prescription.

Licensed Provider – A hospital, health care facility, or health care professional appropriately licensed, certified, or otherwise authorized by the state in which the entity is located or in which he or she practices that provides covered services within the scope of the licensure, certification, or authorization.

Maintenance Care - Any service or activity that seeks to prevent disease, prolong life, or promote health of an asymptomatic person who has reached the maximum level of improvement and whose condition is resolved or stable.

Medical Nutrition Therapy - services provided by a registered dietitian, involving the assessment of the Participant’s overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition such as cardiovascular disease, diabetes mellitus, hypertension, kidney disease, eating disorders, gastrointestinal disorders, seizure disorders (e.g., ketogenic diet), and other conditions based on the efficacy of diet and lifestyle on the treatment of these disease states. Registered dietitians, working in a coordinated, multidisciplinary team effort with the primary care physician, take into account a Participant’s food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

Medically Necessary Care - Any health care treatment, service or supply determined by the Plan to meet each of these requirements:

- 1) It is ordered by a Physician for the diagnosis or treatment of a Sickness or Injury;
- 2) The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person’s medical condition; and
- 3) It is furnished by a provider with appropriate training and experience, acting within the scope of his or her license, and it is provided at the most appropriate level of care needed to treat the particular condition.

The Plan will determine whether these requirements have been met based on:

- 1) Published reports in authoritative medical and scientific literature and is not considered experimental or investigational;
- 2) Regulations, reports, publications or evaluations issued by government agencies such as the National Institutes of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS);
- 3) Listings in Compendia, such as: *The American Hospital Formulary Service Drug Information* and the *United States Pharmacopoeia Dispensing Information*; and
- 4) Other authoritative medical resources to the extent the Plan determines them to be necessary.

Service or supplies that are for the convenience of a Participant or provider are not considered medically necessary. When specifically applied to inpatient care, medically necessary also means the Participant's condition could not be treated safely on an outpatient basis.

Off-label drug use is considered medically necessary when all of the following conditions are met:

- a. The drug is approved by the FDA;
- b. The prescribed drug use is supported by one of the following standard reference sources:
 - 1) DRUGDEX;
 - 2) The American Hospital Formulary Service Drug Information;
 - 3) Medicare approved Compendia; or
 - 4) Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition; and
- c. The drug is medically necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

Medicare - The programs established by Title XVIII of Public Law 89-97 (79 Statutes 291), as amended, entitled Health Insurance for the Aged Act.

Morbid Obesity - A diagnosed condition in which an individual's body weight exceeds the normal weight by 100 pounds or has a body mass index (BMI) of 40 or more (35 with certain co-morbid conditions). The excess weight must cause a condition such as physical trauma, pulmonary, and circulatory insufficiency, diabetes, or heart disease.

Non-Participating Provider – A Licensed Provider outside the CFA service area that does not have a contractual agreement with a Host Blue.

Out-of-Network Provider – A Licensed Provider that is not an In-Network Provider.

Palliative Treatment - Treatment that relieves symptoms for a time but does not cure or end the cause of symptoms.

Partial Hospitalization - Medically directed intensive, or intermediate short-term, mental health and substance use disorder treatment, for a period of less than 24 hours but more than four hours in a day in a licensed or certified facility or program.

Participant - An eligible Employee or eligible Dependent who has elected coverage in this Plan and fulfilled all requirements to continue participation.

Participating Provider – A Licensed Provider outside the CFA service area that has a contractual agreement with a Host Blue.

Physician - A Licensed Provider holding a degree of Doctor of Medicine (MD), Osteopath (DO), Podiatrist (DPM), Psychologist (PhD), Dentist (DDS or DMD), or Chiropractor (DC).

Placement for Adoption - The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Plan - The plan of benefits as contained in the Plan Document and Summary Plan Description, this Summary of Benefits, and any agreements, schedules, and amendments endorsed by the Plan Sponsor.

Plan Administrator - The person/organization responsible for the day-to-day functions and management of this Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. The Plan Administrator is The Johns Hopkins University.

Plan Sponsor / Sponsor - Section 3(16)(B) of ERISA defines the Plan Sponsor as the Employer who establishes a single employer plan. The Plan Sponsor is The Johns Hopkins University.

Plan Year - The 12-month period from April 1 through March 31.

Professional Nutritional Counseling - Individualized advice and guidance given to a Participant at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a registered licensed dietitian or other eligible Health Care Provider.

Prosthetic Device - A device which:

1. Is primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or
2. Is primarily intended to replace all or part of an organ or body part that was absent from birth; or
3. Is intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and
4. Is prescribed by a health care provider; and
5. Is removable and attached externally to the body.

Protected Health Information (PHI) - Individually identifiable health information which is maintained or transmitted by a health plan.

Qualifying Payment Amount – An amount calculated based on the median contracted rate for all plans offered by CareFirst in the self-funded group medical benefits plan market for the same or similar item or service that is:

1. Provided by a health care provider in the same or similar specialty or facility of the same or similar facility type; and
2. Provided in the geographic region in which the item or service is furnished.

Recognized Amount - An amount determined as follows:

1. In a state or jurisdiction that has an applicable All-Payer Model Agreement, the amount that the state or jurisdiction approves under the All-Payer Model Agreement for the particular covered service.
2. If there is no applicable All-Payer Model Agreement, in a state or jurisdiction that has in effect an applicable law, the amount for the covered service determined in accordance with the law.
3. If neither an applicable All-Payer Model Agreement nor law apply to the specific covered service, the lesser of:

- a. The Out-of-Network Provider's actual charge; or
- b. The Qualifying Payment Amount.

Rehabilitation Facility - A facility that mainly provides therapeutic and restorative services to sick or injured people to restore bodily function after an inpatient hospitalization for a debilitating illness or injury. Inpatient rehabilitation, provided by a licensed or certified facility in the jurisdiction in which care is rendered, must be medically necessary, that is the patient's condition must require supplementary skilled care in addition to physical therapy and/or occupational therapy. The expectation is to restore the Participant to enable him/her to live outside of an institution.

Residential Crisis Services - Intensive mental health and support services that are:

1. Provided to a child or an adult Participant with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the ability of the Participant to function in the community; and
2. Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, shorten the length of inpatient stay, or reduce the pressure on general hospital emergency departments; and
3. Provided by entities that are licensed by the applicable licensing laws of any state or the District of Columbia to provide Residential Crisis Services; or
4. Located in subacute beds in an inpatient psychiatric facility for an adult Participant.

Residential Treatment Facility - A facility licensed or certified by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug, or substance use disorders or mental health conditions.

Security Incidents - The term "Security Incidents" has the meaning set forth in 45 CFR § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Skilled Care - Care which requires the technical proficiency and scientific skills of a Registered Nurse (RN) or Licensed Practical or Vocational Nurse (LPN/LVN). Skilled nursing services include, but are not limited to, the following:

- a. Intravenous or intramuscular injections;
- b. Administration of total parenteral nutrition, chemotherapy drugs, blood products, medications, and solutions via intravenous or central venous catheters;
- c. Levine tube and gastrostomy feedings (until a maintenance level is reached);
- d. Naso-pharyngeal and tracheostomy aspiration (until a maintenance level is reached);
- e. Insertion or replacement of catheters and sterile irrigations of catheters; or
- f. Care of extensive decubitus ulcers, infected wounds or other severe skin disruptions requiring sterile technique and skilled application of dressings, and medications.

Surgery - The performance of generally accepted operative and cutting procedures, as well as the following:

- a. Specialized instrumentations, endoscopic examinations and other invasive procedures;
- b. Correction of fractures and dislocations;
- c. Usual and related pre-operative and post-operative care;
- d. Pregnancy, childbirth or miscarriage and complications thereof, and circumcision; or
- e. Other procedures as reasonably approved by the Claims Administrator.

Telemedicine – The use of interactive audio, video, or other electronic media for the purpose of consultation, diagnosis, or treatment of a patient from a site other than where the patient is located. Telemedicine services may be furnished by a Designated or Non-Designated Provider.

Treating Health Care Provider - A physician or other health care provider who has evaluated the Participant.

Urgent Care - Treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to a hospital emergency room or department.

For purposes of Emergency Services, an Urgent Care facility is considered an Independent Freestanding Emergency Department (i.e., an Emergency Facility), if the Urgent Care facility:

1. Is located in a state where health care facility licensure laws allow Urgent Care facilities to provide Emergency Services;
2. Is geographically separate and distinct from a hospital; and
3. Is licensed separately from a hospital.

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

Whether a claim is an Urgent Care Claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a physician with knowledge of the Claimant's medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim for purposes of this claims and appeals process.

Utilization Management Vendor - The Utilization Management Vendor is Quantum Health. Their telephone number is 844-460-2801.

CHAPTER 2

MEDICAL BENEFITS

Payment for any of the following expenses is subject to all Plan exclusions, limitations, and provisions.

You are entitled to the covered services described in this document. Covered services are subject to the deductible, coinsurance, and copay as indicated. Services that are not listed in this document or that are included in the *Limitations and Exclusions* section are not covered services.

Utilization Management Requirements - Utilization Management requirements may apply to certain covered services. When the Utilization Management requirements are not met, payments may be denied or reduced. Refer to Chapter 4 for these requirements.

**RETIREE CORE PPO PLAN
SCHEDULE OF BENEFITS**

DEDUCTIBLE per Plan Year	IN-NETWORK	OUT-OF-NETWORK
Individual	\$500	\$1,000
Family	\$1,500	\$3,000

The deductible is the amount of eligible expenses you must pay each Plan Year for certain covered services, before the Plan pays the benefit amounts shown in this Schedule of Benefits. The remaining percentage, for which you are responsible, is called coinsurance.

Individual Coverage: The Participant must meet the individual deductible each Plan Year before benefits begin.

Family Coverage: All family members' eligible expenses apply to the family deductible, which must be met each Plan Year before benefits begin for all covered family members. When calculating the family deductible, each family member may contribute up to the individual deductible amount, after which the family member will be eligible for benefits.

Eligible expenses apply to both the in-network deductible and the out-of-network deductible.

The following expenses do not apply to the deductible: copays, Prescription Drug Plan expenses, pre-certification penalties, non-covered services, and charges in excess of the Allowed Benefit.

**RETIREE CORE PPO PLAN
SCHEDULE OF BENEFITS**

OUT-OF-POCKET MAXIMUM per Plan Year	IN-NETWORK	OUT-OF-NETWORK
Individual	\$2,000	\$4,000
Family	\$6,000	\$8,000

The out-of-pocket maximum is the maximum dollar amount you are responsible for paying under the Medical Plan and the Prescription Drug Plan during a Plan Year, including the deductible, coinsurance, and copays.

Individual Coverage: After the individual out-of-pocket maximum is reached, the Plan will pay 100% of the Allowed Benefit for the remainder of the Plan Year.

Family Coverage: All family members' eligible expenses apply to the family out-of-pocket maximum. After it is reached, the Plan will pay 100% of the Allowed Benefit for the remainder of the Plan Year. When calculating the family out-of-pocket maximum, each family member may contribute up to the individual out-of-pocket maximum amount, after which the Plan will pay 100% of the Allowed Benefit for that family member's covered services for the remainder of the Plan Year.

Eligible expenses apply to both the in-network out-of-pocket maximum and the out-of-network out-of-pocket maximum.

A copay is the flat dollar amount shown in the Schedule of Benefits that you are required to pay for certain covered services. Copays will not be charged after the out-of-pocket maximum has been reached.

The following expenses do not apply to the out-of-pocket maximum: pre-certification penalties, non-covered services, and charges in excess of the Allowed Benefit.

Hospital and Other Facility Services		Retiree Core PPO Plan
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital	\$250 copay, then 80% of Allowed Benefit After deductible Pre-certification required	\$250 copay, then 70% of Allowed Benefit After deductible Pre-certification required
Diagnostic Tests, Labs, Radiology, Pathology - Outpatient	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Other Radiology & Imaging Services - MRI, MRA, PETScan, CTScan and Nuclear Medicine	80% of Allowed Benefit After deductible Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Emergency Room <i>Copay waived if admitted</i>	\$150 copay, then 100% of Allowed Benefit	\$150 copay, then 100% of Allowed Benefit In-network out-of-pocket maximum applies to this service
Emergency Room – Observation greater than 23 hours <i>Copay waived if admitted</i>	\$150 copay, then 100% of Allowed Benefit Pre-certification required	\$150 copay, then 100% of Allowed Benefit In-network out-of-pocket maximum applies to this service Pre-certification required
Ambulatory Surgical Facility	100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Extended Care Facility / Skilled Nursing Facility <i>Limited to one hundred and twenty (120) days per Plan Year</i>	\$250 copay, then 80% of Allowed Benefit After deductible Pre-certification required	\$250 copay, then 70% of Allowed Benefit After deductible Pre-certification required
Rehabilitation Facility	\$250 copay, then 80% of Allowed Benefit After deductible Pre-certification required	\$250 copay, then 70% of Allowed Benefit After deductible Pre-certification required
Outpatient - Illness	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Outpatient - Surgery	100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Clinic Visit	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Occupational Therapy <i>Limited to ninety (90) visits per illness or injury combined with Physical Therapy and Speech Therapy per Plan Year</i>	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Physical Therapy <i>Limited to ninety (90) visits per illness or injury combined with Occupational Therapy and Speech Therapy per Plan Year</i>	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Speech Therapy	80% of Allowed Benefit	70% of Allowed Benefit

Limited to ninety (90) visits per illness or injury combined with Physical Therapy and Occupational Therapy per Plan Year	After deductible	After deductible
Renal Dialysis	80% of Allowed Benefit After deductible Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Respiratory Therapy	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Chemotherapy	80% of Allowed Benefit After deductible Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Radiation Therapy	80% of Allowed Benefit After deductible Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Professional Services		Retiree Core PPO Plan
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Home Visits <i>Limited to one (1) visit following childbirth, mastectomy, or testicular surgery</i>	100% of Allowed Benefit	100% of Allowed Benefit
Other Radiology & Imaging Services - MRI, MRA, PETScan, CTScan and Nuclear Medicine	80% of Allowed Benefit After deductible Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Diagnostic Tests, Labs, Radiology, Pathology	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Physician Visit – Telephone Consultation	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Physician Visit - Telemedicine (Designated)	\$20 copay, then 100% of Allowed Benefit	Not covered
Physician Visit - Telemedicine (Non-Designated Provider)	Same as any covered service	Same as any covered service
Vision Therapy	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Physician Visit - PCP	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Physician Visit - Specialist	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Anesthesia - Inpatient	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Anesthesia - Outpatient	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Chiropractic Care. <i>Limited to thirty (30) visits per Plan Year</i>	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Emergency Services in the Emergency Room	80% of Allowed Benefit After deductible	80% of Allowed Benefit After in-network deductible In-network out-of-pocket maximum applies to this service
Hyperbaric Oxygen Therapy	80% of Allowed Benefit	70% of Allowed Benefit

	After deductible	After deductible
Physician Visit – Inpatient	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Oral Surgery	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Occupational Therapy <i>Limited to ninety (90) visits per illness or injury combined with Physical Therapy and Speech Therapy per Plan Year</i>	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Physical Therapy <i>Limited to ninety (90) visits per illness or injury combined with Occupational Therapy and Speech Therapy per Plan Year</i>	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Speech Therapy <i>Limited to ninety (90) visits per illness or injury combined with Physical Therapy and Occupational Therapy per Plan Year</i>	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Respiratory Therapy	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Renal Dialysis	80% of Allowed Benefit After deductible Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Second Surgical Opinion	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Surgery - Inpatient	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Surgery - Outpatient	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Surgery - Physician’s Office	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Surgical Assistant – Inpatient	80% of Allowed Benefit After deductible	80% of Allowed Benefit After in-network deductible
Surgical Assistant – Outpatient	80% of Allowed Benefit After deductible	80% of Allowed Benefit After in-network deductible
Chemotherapy	80% of Allowed Benefit After deductible Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Radiation Therapy	80% of Allowed Benefit After deductible Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Other Eligible Services		Retiree Core PPO Plan
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Acupuncture <i>Limited to thirty (30) visits per Plan Year</i>	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Air Ambulance	80% of Allowed Benefit After deductible Pre-certification required	80% of Allowed Benefit After in-network deductible In-network out-of-pocket

	for non-emergencies only	maximum applies to this service Pre-certification required for non-emergencies only
Ambulance	80% of Allowed Benefit After deductible	80% of Allowed Benefit After in-network deductible In-network out-of-pocket maximum applies to this service
Allergy Shots / Serum	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Allergy Testing	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Biofeedback Therapy	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Cardiac Rehabilitation	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Cleft Lip/ Palate	Same as any covered service	Same as any covered service
Clinical Trials - Patient Costs	Same as any covered service Pre-certification required	Same as any covered service Pre-certification required
Dental Services	Same as any covered service	Same as any covered service
Diabetes Management	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Durable Medical Equipment (DME)	80% of Allowed Benefit After deductible Pre-certification required per purchase or rental in excess of \$1,500	70% of Allowed Benefit After deductible Pre-certification required per purchase or rental in excess of \$1,500
Family Counseling	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Footwear - Diabetic shoes and inserts	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Footwear - Orthopedic/Therapeutic Shoes	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Footwear - Orthotic Foot Inserts	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Gender Affirmation Services	Same as any covered service	Same as any covered service
Genetic Testing and Counseling (Other than Prenatal)	80% of Allowed Benefit After deductible Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Habilitative Services	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Hearing Aid Fitting and Evaluation	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Hearing Aids for Adults <i>Limited to \$3,000 per hearing-impaired ear every thirty-six (36) months</i>	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible

Hearing Aids for a Minor Dependent Child <i>Limited to one (1) hearing aid for each hearing-impaired ear per thirty-six (36) months up to age eighteen (18)</i>	100% of Allowed Benefit	100% of Allowed Benefit
Home Health Care <i>Limited to Hospital/ Home Health Agency. One hundred and twenty (120) days per Plan Year combined with Outpatient Private Duty Nursing</i>	100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Hospice - Bereavement Counseling <i>Limited to three (3) visits following the family member's death per Plan Year</i>	100% of Allowed Benefit	70% of Allowed Benefit After deductible
Hospice - Family Counseling <i>Limited to three (3) visits per Plan Year</i>	100% of Allowed Benefit	70% of Allowed Benefit After deductible
Hospice - Inpatient Care	100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Hospice - Outpatient Care	100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Hospice - Respite Care <i>Limited to fourteen (14) days per Plan Year</i>	100% of Allowed Benefit	70% of Allowed Benefit After deductible
Infusion Therapy	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Injections / Injectables	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Medical Foods and Nutritional Substances	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Medical Supplies	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Nutritional Counseling	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Orthotic Device	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Pediatric/Infant Feeding Programs	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Pre-admission Testing	100% of Allowed Benefit	100% of Allowed Benefit
Private Duty Nursing - Outpatient <i>Limited to one hundred and twenty (120) days per Plan Year combined with Home Health Care</i>	80% of Allowed Benefit After deductible Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Prosthetic Device (Except leg, arm, and eye)	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Prosthetic Device - leg, arm, and eye	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Pulmonary Rehabilitation	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Sleep Studies - Attended	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible

Sleep Studies - Unattended	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Temporomandibular Joint (TMJ) Disorder - Non-Surgical	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Temporomandibular Joint (TMJ) Disorder - Surgical	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Transportation and Lodging <i>Limited to \$10,000 per Plan Year</i>	Transportation – 100% of transportation costs Lodging – Up to \$50 per day per Participant Benefit applies when any covered service under the medical Plan is inaccessible within 50 miles of home zip code After in-network deductible	
Urgent Care Center Visit	\$50 copay, then 100% of Allowed Benefit	70% of Allowed Benefit After deductible
Walk-In Clinic Visit	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Wig <i>Limited to one (1) wig up to \$1,000 per Plan Year</i>	100% of Allowed Benefit	100% of Allowed Benefit
Applied Behavior Analysis (ABA) Services		Retiree Core PPO Plan
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Applied Behavioral Analysis	Same as any covered service	Same as any covered service
Maternity Services		Retiree Core PPO Plan
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Genetic Testing (Prenatal)	80% of Allowed Benefit After deductible Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Birth Classes	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Prenatal Care as defined under Women’s Preventive Services, as specified by the Patient Protection and Affordable Care Act	100% of Allowed Benefit	70% of Allowed Benefit After deductible
Inpatient Hospital – Mother	\$250 copay, then 80% of Allowed Benefit After deductible Pre-certification required	\$250 copay, then 70% of Allowed Benefit After deductible Pre-certification required
Inpatient Hospital – Newborn	\$250 copay, then 80% of Allowed Benefit After deductible Pre-certification required	\$250 copay, then 70% of Allowed Benefit After deductible Pre-certification required
Birth Center	80% of Allowed Benefit After deductible Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Delivery	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Anesthesia	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Diagnostic Tests, Labs, Radiology,	80% of Allowed Benefit	70% of Allowed Benefit

Pathology	After deductible	After deductible
Prenatal and Postnatal Office Visits not billed with delivery	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Abortion Care Services	100% of Allowed Benefit	100% of Allowed Benefit
Organ Transplants		Retiree Core PPO Plan
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital	\$250 copay, then 80% of Allowed Benefit After deductible Pre-certification required	\$250 copay, then 70% of Allowed Benefit After deductible Pre-certification required
Anesthesia	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Transplant Procedure	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Diagnostic Tests, Labs, Radiology, Pathology	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Donor Expenses	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Procurement	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Mental Health and Substance Use Disorder Services		Retiree Core PPO Plan
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Methadone Maintenance	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Physician Visit - Telemedicine (Designated Provider)	\$20 copay, then 100% of Allowed Benefit	Not covered
Physician Visit - Telemedicine (Non-Designated Provider)	Same as any covered service	Same as any covered service
Office Visit	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Emergency Room – Observation greater than 23 hours <i>Copay waived if admitted</i>	\$150 copay, then 100% of Allowed Benefit Pre-certification required	\$150 copay, then 100% of Allowed Benefit Pre-certification required In-network out-of-pocket maximum applies to this service Pre-certification required
Inpatient Hospital	\$250 copay, then 80% of Allowed Benefit After deductible Pre-certification required	\$250 copay, then 70% of Allowed Benefit After deductible Pre-certification required
Residential Treatment Facility	\$250 copay, then 80% of Allowed Benefit After deductible Pre-certification required	\$250 copay, then 70% of Allowed Benefit After deductible Pre-certification required
Partial Hospitalization	80% of Allowed Benefit After deductible Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Inpatient Visits	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible

Intensive Outpatient Services	80% of Allowed Benefit After deductible Pre-certification required	70% of Allowed Benefit After deductible Pre-certification required
Outpatient Visits	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Outpatient Facility	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Psychiatric Testing	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Infertility Services <i>Infertility lifetime limit: \$100,000 for all Medical Plan services and Prescription Drugs combined</i>		Retiree Core PPO Plan
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Artificial Insemination (AI) <i>Benefits for artificial insemination (AI) and / or intrauterine insemination (IUI) are limited to six (6) attempts per live birth and up to a lifetime maximum benefit of \$100,000 combined with IVF and Prescription Drugs</i>	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Intra-Uterine Insemination (IUI) <i>Benefits for artificial insemination (AI) and/ or intrauterine insemination (IUI) are limited to six (6) attempts per live birth and up to a lifetime maximum benefit of \$100,000 combined with IVF and Prescription Drugs</i>	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
In-Vitro Fertilization (IVF) <i>Benefits for in-vitro fertilization (IVF) are limited to three (3) attempts per live birth; and a lifetime maximum of \$100,000 combined with AI/IUI and Prescription Drugs</i>	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Gamete Intra-Fallopian Transfer (GIFT) <i>Benefits for (GIFT) are limited to three (3) attempts per live birth; and a lifetime maximum of \$100,000 combined with AI/IUI and Prescription Drugs</i>	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Zygote Intra-Fallopian Transfer (ZIFT) <i>Benefits for (ZIFT) are limited to three (3) attempts per live birth; and a lifetime maximum of \$100,000 combined with AI/IUI and Prescription Drugs</i>	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Cryopreservation Storage <i>Limited to twelve (12) months for Participants undergoing imminent fertility treatment or for Participants with Iatrogenic infertility (including</i>	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible

gender affirmation surgery) and up to a lifetime maximum benefit of \$100,000 combined with all Medical Plan services and prescription drugs		
Preimplantation Genetic Testing (PGT) Limited to a lifetime maximum benefit of \$100,000 combined with all Medical Plan services and prescription drugs	80% of Allowed Benefit After deductible	70% of Allowed Benefit After deductible
Preventive Services A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits .		Retiree Core PPO Plan
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Preventive Service for Adults and Children as specified by the Affordable Care Act	100% of Allowed Benefit	70% of Allowed Benefit After deductible
Skin Cancer Screening	100% of Allowed Benefit	70% of Allowed Benefit After deductible
Women's Preventive Services, as specified by the Affordable Care Act	100% of Allowed Benefit	70% of Allowed Benefit After deductible

Notes:

1. To obtain in-network benefits, a provider must participate in the network at the time services are rendered. Contact the provider or the network before you receive services to verify that the provider participates in the network. Refer to your network directory for a list of In-Network Providers.
2. Claims for covered services rendered by Out-of-Network Providers may be submitted directly to CareFirst by the Out-of-Network Provider, or the Participant may need to submit the claim. In either case, it is the responsibility of the Participant to make sure that all claims are filed on time.
 - a. For Emergency Services provided by an Out-of-Network Provider:
 - 1) All benefits for covered services will be payable directly to the Out-of-Network Provider.
 - 2) In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the State of Maryland Department of Health or the non-insuring parent if proof is provided that such parent has paid the Out-of-Network Provider.
 - 3) The Participant is not responsible for the difference between CareFirst's payment and the Out-of-Network Provider's charge.
 - 4) Benefits for Emergency Services by Out-of-Network Providers are available to the same extent as benefits available for Emergency

Services provided by In-Network Providers. See the Schedule of Benefits for details.

b. For covered services provided by an Out-of-Network Provider in an in-network facility (including Ancillary Services and Services for unforeseen urgent medical needs):

1) Except when the Out-of-Network Provider satisfies the Notice and Consent Requirements (described below):

- a) All benefits for covered services will be payable directly to the Out-of-Network Provider.
- b) In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the State of Maryland Department of Health or the non-insuring parent if proof is provided that such parent has paid the Out-of-Network Provider.
- c) The Participant is not responsible for the difference between CareFirst's payment and the Out-of-Network Provider's charge.
- d) Benefits for covered services provided by an Out-of-Network Provider in an in-network facility (including Ancillary Services and services for unforeseen urgent medical needs) are available to the same extent as benefits available for covered services provided by In-Network Providers. See the Schedule of Benefits for details.

2) Notice and Consent Requirements

a) The Out-of-Network Provider satisfies the notice and consent criteria of 45 C.F.R. §149.420, by:

- (1) Providing to the Participant notice that the health care provider is an Out-of-Network Provider, and an estimate of the charges for the covered services; and
- (2) Obtaining consent from the Participant (or the Participant's Authorized Representative) to be treated and balance billed by the Out-of-Network Provider.

b) When the Out-of-Network Provider satisfies the notice and consent requirements, covered services are subject to the provisions of section 2.c., below.

c) Notice and consent requirements described above, do not apply to:

- (1) Ancillary Services; and

- (2) Covered services provided as a result of unforeseen, urgent medical needs, that arise at the time other covered services are being rendered, regardless of whether the Out-of-Network Provider satisfied the notice and consent requirements.

These covered services are always subject to the provisions of section 2.b.1) above.

- c. For all other covered services provided by an Out-of-Network Provider (except as otherwise authorized by CareFirst or stated in this document):
 - 1) If a Participant chooses an Out-of-Network Provider, covered services may be eligible for reduced benefits.
 - 2) All benefits for covered services will be payable to the Participant, or to the Out-of-Network Provider, at the discretion of CareFirst.
 - 3) In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the State of Maryland Department of Health or the non-insuring parent if proof is provided that such parent has paid the Out-of-Network Provider.
 - 4) Out-of-Network Providers are not required to accept the Allowed Benefit as full payment and will collect additional amounts from the Participant up to the provider's actual charge. The Allowed Benefit may be substantially less than the provider's actual charge to the Participant. Therefore, when covered services are provided by Out-of-Network Providers, Participants should expect to pay additional amounts to providers that exceed the Allowed Benefit. The Participant is responsible for the difference between CareFirst's payment and the Out-of-Network Provider's charge.
3. Any copayment, coinsurance, and/or other cost-sharing requirement for services provided by Out-of-Network Providers **will be the same** as the copayment, coinsurance, and/or other cost-sharing requirement stated in this Schedule of Benefits for services provided by In-Network Providers, for the following services:
 - a. Emergency Services provided by Out-of-Network Providers.
 - b. Air Ambulance Services provided by Out-of-Network Providers.
 - c. Non-emergency services provided by Out-of-Network Providers at in-network facilities (including Ancillary Services and services for unforeseen urgent medical needs), except when the Out-of-Network Provider has satisfied the Notice and Consent Requirements of 45 C.F.R. §149.420 (c) through (i), as stated in Note #2. b. 2), above.
 - d. Services provided by an Out-of-Network Provider, when the Participant relied on a database, provider directory, or information provided by CareFirst regarding the health care provider's status (through a telephone call or electronic means) which

incorrectly indicated that the health care provider was an In-Network Provider for the services received.

4. All cost-share payments made by the Participant for the following services, will contribute towards the in-network deductible and out-of-pocket:
 - a. Emergency Services provided by Out-of-Network Providers.
 - b. Air Ambulance Services provided by Out-of-Network Providers
 - c. Non-emergency services provided by Out-of-Network Providers at in-network facilities (including Ancillary Services and services for unforeseen urgent medical needs), except when the Out-of-Network Provider has satisfied the Notice and Consent Requirements of 45 C.F.R. §149.420 (c) through (i), as stated in Note #2. b. 2), above.
 - d. Services provided by an Out-of-Network Provider, when the Participant relied on a database, provider directory, or information provided by CareFirst regarding the health care provider's status (through a telephone call or electronic means) which incorrectly indicated that the health care provider was an In-Network Provider for the services received.
5. In the event a Participant is a continuing care patient receiving a course of treatment from a provider which is in-network and that provider is terminated, not renewed, or otherwise ends for any reason other than the provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Participant shall be notified in a timely manner and that the Participant has rights to elect continued transitional care from the provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Participant was notified of the provider's termination and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

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

- a. is undergoing a course of treatment for a serious and complex condition from a specific provider,
- b. is undergoing a course of institutional or Inpatient care from a specific provider,
- c. is scheduled to undergo non-elective surgery from a specific provider, including receipt of postoperative care with respect to the surgery,
- d. is pregnant and undergoing a course of treatment for the Pregnancy from a specific provider, or
- e. is or was determined to be terminally ill and is receiving treatment for such illness from a specific provider.

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

6. The physician office visit copay includes the following services, if performed in the office and billed by the physician: radiology, pathology, laboratory, and other diagnostic tests; surgery; allergy shots / serum; and injections / injectables.
7. Benefit limits include both in-network and out-of-network services.
8. The following professional services will be paid at the in-network benefit level when rendered at an in-network facility: anesthesia; emergency services; consultations; surgical assistance; and radiology, pathology, laboratory, and other diagnostic tests.
9. If it is verified by the Claims Administrator that a needed service is not available in the network, benefits will be paid at the in-network benefit level. To qualify for this benefit, there must be no In-Network Provider for the needed service within 50 miles from the Participant's residence. A Service Availability Form must be completed and sent to the Claims Administrator.
10. If you are admitted as an inpatient immediately following an out-of-network emergency room visit where you received emergency services, inpatient services rendered during the initial confinement will be paid at the in-network benefit level. Except as stated in the Emergency Services subsection of the Covered Services section of this document, any out-of-network treatment following the initial confinement will be paid as any other covered service, as shown in the Schedule of Benefits.
11. For purposes of determining copay amounts, a Primary Care Provider (PCP) is either a nurse practitioner or a physician practicing in the following disciplines: general practice, family practice, internal medicine, pediatrics, obstetrics / gynecology, or geriatrics. All other physicians are considered specialists, unless otherwise required by applicable law.
12. Any lifetime limit applies to all benefit plan options within the Plan and represents the maximum amount of benefits a Participant is eligible to receive during the entire time the Participant is covered under the Plan.

RETIREE LIUNA BU NETWORK ONLY PLAN SCHEDULE OF BENEFITS		
DEDUCTIBLE per Plan Year	IN-NETWORK	OUT-OF-NETWORK
Individual	Not applicable	Not applicable
Family	Not applicable	Not applicable
<p>The deductible is the amount of eligible expenses you must pay each Plan Year for certain covered services, before the Plan pays the benefit amounts shown in this Schedule of Benefits. The remaining percentage, for which you are responsible, is called coinsurance.</p> <p>There is no deductible.</p> <p>The following expenses do not apply to the deductible: copays, Prescription Drug Plan expenses, pre-certification penalties, non-covered services, and charges in excess of the Allowed Benefit.</p>		

RETIREE LIUNA BU NETWORK ONLY PLAN SCHEDULE OF BENEFITS		
OUT-OF-POCKET MAXIMUM per Plan Year	IN-NETWORK	OUT-OF-NETWORK
Individual	\$2,000	Not applicable
Family	\$6,000	Not applicable
<p>The out-of-pocket maximum is the maximum dollar amount you are responsible for paying under the Medical Plan and the Prescription Drug Plan during a Plan Year, including coinsurance, and copays.</p> <p><u>Individual Coverage:</u> After the individual out-of-pocket maximum is reached, the Plan will pay 100% of the Allowed Benefit for the remainder of the Plan Year.</p> <p><u>Family Coverage:</u> All family members' eligible expenses apply to the family out-of-pocket maximum. After it is reached, the Plan will pay 100% of the Allowed Benefit for the remainder of the Plan Year. When calculating the in-network family out-of-pocket maximum, each family member may contribute up to the individual out-of-pocket maximum amount, after which the Plan will pay 100% of the Allowed Benefit for that family member's in-network covered services for the remainder of the Plan Year.</p> <p>A copay is the flat dollar amount shown in the Schedule of Benefits that you are required to pay for certain covered services. Copays will not be charged after the in-network out-of-pocket maximum has been reached.</p> <p>The following expenses do not apply to the out-of-pocket maximum: pre-certification penalties, non-covered services, and charges in excess of the Allowed Benefit.</p>		

Hospital and Other Facility Services ..		Retiree LiUNA BU Network Only Plan	
Covered Services	IN-NETWORK	OUT-OF-NETWORK	
Inpatient Hospital	\$250 copay, then 100% of Allowed Benefit Pre-certification required	Not covered	
Diagnostic Tests, Labs, Radiology, Pathology - Outpatient	100% of Allowed Benefit	Not covered	
Other Radiology & Imaging Services - MRI, MRA, PETScan, CTScan and Nuclear Medicine	100% of Allowed Benefit Pre-certification required	Not covered	
Emergency Room <i>Copay waived if admitted</i>	\$100 copay, then 100% of Allowed Benefit	\$100 copay, then 100% of Allowed Benefit In-network out-of-pocket maximum applies to this service	
Emergency Room – Observation greater than 23 hours <i>Copay waived if admitted</i>	\$100 copay, then 100% of Allowed Benefit Pre-certification required	\$100 copay, then 100% of Allowed Benefit In-network out-of-pocket maximum applies to this service Pre-certification required	
Ambulatory Surgical Facility	100% of Allowed Benefit Pre-certification required	Not covered	
Extended Care Facility / Skilled Nursing Facility <i>Limited to one-hundred and twenty (120) days per Plan Year</i>	\$250 copay, then 100% of Allowed Benefit Pre-certification required	Not covered	
Rehabilitation Facility	\$250 copay, then 100% of Allowed Benefit Pre-certification required	Not covered	
Outpatient - Illness	100% of Allowed Benefit	Not covered	
Outpatient - Surgery	100% of Allowed Benefit Pre-certification required	Not covered	
Clinic Visit	100% of Allowed Benefit	Not covered	
Occupational Therapy <i>Limited to ninety (90) visits per illness or injury combined with Physical Therapy and Speech Therapy per Plan Year</i>	100% of Allowed Benefit	Not covered	
Physical Therapy <i>Limited to ninety (90) visits per illness or injury combined with Occupational Therapy and Speech Therapy per Plan Year</i>	100% of Allowed Benefit	Not covered	
Speech Therapy <i>Limited to ninety (90) visits per illness or injury combined with Physical Therapy and Occupational Therapy per Plan Year</i>	100% of Allowed Benefit	Not covered	
Renal Dialysis	100% of Allowed Benefit Pre-certification required	Not covered	

Respiratory Therapy	100% of Allowed Benefit	Not covered
Chemotherapy	100% of Allowed Benefit Pre-certification required	Not covered
Radiation Therapy	100% of Allowed Benefit Pre-certification required	Not covered
Retiree LiUNA BU Network Only Plan		
Professional Services		
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Home Visits <i>Limited to one (1) visit following childbirth, mastectomy, or testicular surgery</i>	100% of Allowed Benefit	Not covered
Other Radiology & Imaging Services - MRI, MRA, PETScan, CTScan and Nuclear Medicine	100% of Allowed Benefit Pre-certification required	Not covered
Physician Visit – Telephone Consultation	\$20 copay - PCP \$35 copay Specialist then, 100% of Allowed Benefit	Not covered
Physician Visit - Telemedicine (Designated Provider)	\$20 copay, then 100% of Allowed Benefit	Not covered
Physician Visit - Telemedicine (Non-Designated Provider)	Same as any covered service	Not covered
Vision Therapy	\$35 copay, then 100% of Allowed Benefit	Not covered
Physician Visit - PCP	\$20 copay, then 100% of Allowed Benefit	Not covered
Physician Visit - Specialist	\$35 copay, then 100% of Allowed Benefit	Not covered
Anesthesia - Inpatient	100% of Allowed Benefit	Not covered
Anesthesia - Outpatient	100% of Allowed Benefit	Not covered
Chiropractic Care <i>Limited to thirty (30) visits per Plan Year</i>	\$35 copay, then 100% of Allowed Benefit	Not covered
Diagnostic Tests, Labs, Radiology, Pathology	100% of Allowed Benefit	Not covered
Emergency Services in the Emergency Room	100% of Allowed Benefit	100% of Allowed Benefit In-network out-of-pocket maximum applies to this service
Hyperbaric Oxygen Therapy	100% of Allowed Benefit	Not covered
Physician Visit – Inpatient	100% of Allowed Benefit	Not covered
Oral Surgery	100% of Allowed Benefit after \$20 PCP \$35 Specialist copay \$0 Ambulatory surgical professional practitioner	Not covered
Occupational Therapy <i>Limited to ninety (90) visits per illness or injury combined with Physical Therapy and Speech Therapy per Plan Year</i>	\$35 copay, then 100% of Allowed Benefit	Not covered

Physical Therapy <i>Limited to ninety (90) visits per illness or injury combined with Occupational Therapy and Speech Therapy per Plan Year</i>	\$35 copay, then 100% of Allowed Benefit	Not covered
Speech Therapy <i>Limited to ninety (90) visits per illness or injury combined with Physical Therapy and Occupational Therapy per Plan Year</i>	\$35 copay, then 100% of Allowed Benefit	Not covered
Respiratory Therapy	\$35 copay, then 100% of Allowed Benefit	Not covered
Renal Dialysis	100% of Allowed Benefit Pre-certification required	Not covered
Second Surgical Opinion	\$35 copay, then 100% of Allowed Benefit	Not covered
Surgery - Inpatient	100% of Allowed Benefit	Not covered
Surgery - Outpatient	\$100 copay, then 100% of Allowed Benefit	Not covered
Surgery - Physician's Office	100% of Allowed Benefit after \$20 PCP \$35 Specialist Copay	Not covered
Surgical Assistant – Inpatient	100% of Allowed Benefit	Not covered
Surgical Assistant – Outpatient	100% of Allowed Benefit	Not covered
Chemotherapy	\$35 copay, then 100% of Allowed Benefit Pre-certification required	Not covered
Radiation Therapy	\$35 copay, then 100% of Allowed Benefit Pre-certification required	Not covered
Other Eligible Services		
Retiree LiUNA BU Network Only Plan		
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Air Ambulance	100% of Allowed Benefit Pre-certification required for non-emergencies only	100% of Allowed Benefit In-network out-of-pocket maximum applies to this service Pre-certification required for non-emergencies only
Ambulance	100% of Allowed Benefit	100% of Allowed Benefit In-network out-of-pocket maximum applies to this service
Allergy Shots / Serum	100% of Allowed Benefit	Not covered
Allergy Testing	\$20 copay - PCP \$35 copay Specialist then, 100% of Allowed Benefit	Not covered
Biofeedback Therapy	100% of Allowed Benefit	Not covered
Cardiac Rehabilitation	\$35 copay, then 100% of Allowed Benefit	Not covered

Cleft Lip/ Palate	Same as any covered service	Not covered
Clinical Trials - Patient Costs	Same as any covered service Pre-certification required	Not covered
Dental Services	Same as any covered service	Not covered
Diabetes Management	100% of Allowed Benefit	Not covered
Durable Medical Equipment (DME)	100% of Allowed Benefit Pre-certification required per purchase or rental in excess of \$1,500	Not covered
Family Counseling	100% of Allowed Benefit	Not covered
Footwear - Diabetic shoes and inserts	100% of Allowed Benefit	Not covered
Footwear - Orthopedic/Therapeutic Shoes	100% of Allowed Benefit	Not covered
Footwear - Orthotic Foot Inserts	100% of Allowed Benefit	Not covered
Gender Affirmation Services	Same as any covered service	Not covered
Genetic Testing and Counseling (Other than Prenatal)	100% of Allowed Benefit Pre-certification required	Not covered
Habilitative Services	\$35 copay, then 100% of Allowed Benefit	Not covered
Hearing Aid Fitting and Evaluation	\$35 copay, then 100% of Allowed Benefit	Not covered
Hearing Aids for Adults <i>Limited to \$3,000 per hearing-impaired ear every thirty-six (36) months</i>	\$35 copay, then 100% of Allowed Benefit	Not covered
Hearing Aids for a Minor Dependent Child <i>Limited to one (1) hearing aid for each hearing-impaired ear per thirty-six (36) months up to age eighteen (18)</i>	100% of Allowed Benefit	Not covered
Home Health Care <i>Limited to Hospital/ Home Health Agency. One hundred and twenty (120) days per Plan Year combined with Outpatient Private Duty Nursing</i>	100% of Allowed Benefit Pre-certification required	Not covered
Hospice - Bereavement Counseling <i>Limited to three (3) visits following the family member's death per Plan Year</i>	100% of Allowed Benefit	Not covered
Hospice - Family Counseling <i>Limited to three (3) per Plan Year</i>	100% of Allowed Benefit	Not covered
Hospice - Inpatient Care	100% of Allowed Benefit Pre-certification required	Not covered
Hospice - Outpatient Care	100% of Allowed Benefit Pre-certification required	Not covered
Hospice - Respite Care <i>Limited to fourteen (14) days per Plan Year</i>	100% of Allowed Benefit	Not covered
Infusion Therapy	100% of Allowed Benefit	Not covered

	Pre-certification required	
Injections / Injectables	100% of Allowed Benefit	Not covered
Medical Foods and Nutritional Substances	100% of Allowed Benefit	Not covered
Medical Supplies	100% of Allowed Benefit	Not covered
Nutritional Counseling	\$20 copay PCP/ \$35 copay Specialist, then 100% of Allowed Benefit	Not covered
Orthotic Device	100% of Allowed Benefit	Not covered
Pediatric/Infant Feeding Programs	100% of Allowed Benefit	Not covered
Pre-admission Testing	100% of Allowed Benefit	Not covered
Private Duty Nursing - Outpatient <i>Limited to one hundred and twenty (120) days per Plan Year combined with Home Health Care</i>	100% of Allowed Benefit Pre-certification required	Not covered
Prosthetic Device (Except leg, arm, and eye)	100% of Allowed Benefit	Not covered
Prosthetic Device - leg, arm, and eye	\$20 copay, then 100% of Allowed Benefit	Not covered
Pulmonary Rehabilitation	100% of Allowed Benefit	Not covered
Sleep Studies - Attended	100% of Allowed Benefit	Not covered
Sleep Studies - Unattended	100% of Allowed Benefit	Not covered
Temporomandibular Joint (TMJ) Disorder - Non-Surgical	100% of Allowed Benefit	Not covered
Temporomandibular Joint (TMJ) Disorder - Surgical	100% of Allowed Benefit	Not covered
Transportation and Lodging <i>Limited to \$10,000 per Plan Year</i>	Transportation – 100% of transportation costs Lodging – Up to \$50 per day per Participant Benefit applies when any covered service under the medical Plan is inaccessible within 50 miles of home zip code	
Urgent Care Center Visit	\$50 copay, then 100% of Allowed Benefit	Not covered
Vision - Exam <i>Limited to one (1) vision examination per Plan Year</i>	\$10 copay, then 100% of Allowed Benefit	
Walk-In Clinic Visit	100% of Allowed Benefit	Not covered
Wig <i>Limited to one (1) wig up to \$1,000 per Plan Year</i>	100% of Allowed Benefit	Not covered
Applied Behavior Analysis (ABA) Services Retiree LiUNA BU Network Only Plan		
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Applied Behavioral Analysis	Same as any covered service	Not covered
Maternity Services Retiree LiUNA BU Network Only Plan		
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Genetic Testing (Prenatal)	100% of Allowed Benefit Pre-certification required	Not covered
Birthing Classes	100% of Allowed Benefit	Not covered

Prenatal Care as defined under Women’s Preventive Services, as specified by the Patient Protection and Affordable Care Act	100% of Allowed Benefit	Not covered
Inpatient Hospital – Mother	\$250 copay, then 100% of Allowed Benefit Pre-certification required	Not covered
Inpatient Hospital – Newborn	\$250 copay, then 100% of Allowed Benefit Pre-certification required	Not covered
Birth Center	100% of Allowed Benefit Pre-certification required	Not covered
Delivery	100% of Allowed Benefit	Not covered
Anesthesia	100% of Allowed Benefit	Not covered
Diagnostic Tests, Labs, Radiology, Pathology	100% of Allowed Benefit	Not covered
Prenatal and Postnatal Office Visits not billed with delivery	100% of Allowed Benefit	Not covered
Pre and Postnatal (Non-Preventive)	100% of Allowed Benefit	Not covered
Abortion Care Services	100% of Allowed Benefit	Not covered
Retiree LiUNA BU Network Only Plan		
Organ Transplants		
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital	\$250 copay, then 100% of Allowed Benefit Pre-certification required	Not covered
Anesthesia	100% of Allowed Benefit	Not covered
Transplant Procedure	100% of Allowed Benefit	Not covered
Diagnostic Tests, Labs, Radiology, Pathology	100% of Allowed Benefit	Not covered
Donor Expenses	100% of Allowed Benefit	Not covered
Procurement	100% of Allowed Benefit	Not covered
Retiree LiUNA BU Network Only Plan		
Mental Health and Substance Use Disorder Services		
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Methadone Maintenance	\$20 copay – Office \$0 copay – Hospital Facility/ Outpatient professional practitioner, then 100% of Allowed Benefit	Not covered
Physician Visit - Telemedicine (Designated Provider)	\$20 copay, then 100% of Allowed Benefit	Not covered
Physician Visit - Telemedicine (Non-Designated Provider)	Same as any Covered Service	Not covered
Office Visit	\$20 copay, then 100% of Allowed Benefit	Not covered
Emergency Room – Observation Greater than 23 Hours <i>Copay waived if admitted</i>	\$100 copay, then 100% of Allowed Benefit Pre-certification required	\$100 copay, then 100% of Allowed Benefit In-network out-of-pocket maximum applies to this service

		Pre-certification required
Inpatient Hospital	\$250 copay, then 100% of Allowed Benefit Pre-certification required	Not covered
Residential Treatment Facility	\$250 copay, then 100% of Allowed Benefit Pre-certification required	Not covered
Partial Hospitalization	100% of Allowed Benefit Pre-certification required	Not covered
Inpatient Visits	100% of Allowed Benefit	Not covered
Intensive Outpatient Services	100% of Allowed Benefit Pre-certification required	Not covered
Outpatient Visits	100% of Allowed Benefit	Not covered
Outpatient Facility	100% of Allowed Benefit	Not covered
Psychiatric Testing	100% of Allowed Benefit	Not covered
Infertility Services Retiree LiUNA BU Network Only Plan		
<i>Infertility lifetime limit: \$100,000 for all Medical Plan services and Prescription Drugs combined</i>		
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Artificial Insemination (AI) <i>Benefits for artificial insemination (AI) and / or intrauterine insemination (IUI) are limited to six (6) attempts per live birth and up to a lifetime maximum benefit of \$100,000 combined with IVF and Prescription Drugs</i>	50% of Allowed Benefit	Not covered
Intra-Uterine Insemination (IUI) <i>Benefits for artificial insemination (AI) and/ or intrauterine insemination (IUI) are limited to six (6) attempts per live birth and up to a lifetime maximum benefit of \$100,000 combined with IVF and Prescription Drugs</i>	50% of Allowed Benefit	Not covered
In-Vitro Fertilization (IVF) <i>Benefits for in-vitro fertilization (IVF) are limited to three (3) attempts per live birth; and a lifetime maximum of \$100,000 combined with AI/IUI and Prescription Drugs</i>	50% of Allowed Benefit	Not covered
Gamete Intra-Fallopian Transfer (GIFT) <i>Benefits for (GIFT) are limited to three (3) attempts per live birth; and a lifetime maximum of \$100,000 combined with AI/IUI and Prescription Drugs</i>	50% of Allowed Benefit	Not covered
Zygote Intra-Fallopian Transfer (ZIFT) <i>Benefits for (ZIFT) are limited to three (3) attempts per live birth; and a lifetime maximum of \$100,000 combined with AI/IUI and Prescription</i>	50% of Allowed Benefit	Not covered

Drugs		
Cryopreservation Storage <i>Limited to twelve (12) months for Participants undergoing imminent fertility treatment or for Participants with Iatrogenic infertility (including gender affirmation surgery) and up to a lifetime maximum benefit of \$100,000 combined with all Medical Plan services and prescription drugs</i>	50% of Allowed Benefit	Not covered
Preimplantation Genetic Testing (PGT) <i>Limited to a lifetime maximum benefit of \$100,000 combined with all Medical Plan services and prescription drugs</i>	50% of Allowed Benefit	Not covered
Preventive Services Retiree LiUNA BU Network Only Plan		
A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits .		
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Preventive Service for Adults and Children as specified by the Affordable Care Act	100% of Allowed Benefit	Not covered
Skin Cancer Screening	100% of Allowed Benefit	Not covered
Women's Preventive Services, as specified by the Affordable Care Act	100% of Allowed Benefit	Not covered

Notes:

1. To obtain in-network benefits, a provider must participate in the network at the time services are rendered. Contact the provider or the network before you receive services to verify that the provider participates in the network. Refer to your network directory for a list of In-Network Providers.
2. Claims for covered services rendered by Out-of-Network Providers may be submitted directly to CareFirst by the Out-of-Network Provider, or the Participant may need to submit the claim. In either case, it is the responsibility of the Participant to make sure that all claims are filed on time.
 - a. For Emergency Services provided by an Out-of-Network Provider:
 - 1) All benefits for covered services will be payable directly to the Out-of-Network Provider.
 - 2) In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the State of Maryland Department of Health or the non-insuring parent if proof is provided that such parent has paid the Out-of-Network Provider.

- 3) The Participant is not responsible for the difference between CareFirst's payment and the Out-of-Network Provider's charge.
 - 4) Benefits for Emergency Services by Out-of-Network Providers are available to the same extent as benefits available for Emergency Services provided by In-Network Providers. See the Schedule of Benefits for details.
- b. For covered services provided by an Out-of-Network Provider in an in-network facility (including Ancillary Services and Services for unforeseen urgent medical needs):
- 1) Except when the Out-of-Network Provider satisfies the Notice and Consent Requirements (described below):
 - a) All benefits for covered services will be payable directly to the Out-of-Network Provider.
 - b) In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the State of Maryland Department of Health or the non-insuring parent if proof is provided that such parent has paid the Out-of-Network Provider.
 - c) The Participant is not responsible for the difference between CareFirst's payment and the Out-of-Network Provider's charge.
 - d) Benefits for covered services provided by an Out-of-Network Provider in an in-network facility (including Ancillary Services and services for unforeseen urgent medical needs) are available to the same extent as benefits available for covered services provided by In-Network Providers. See the Schedule of Benefits for details.
 - 2) Notice and Consent Requirements
 - a) The Out-of-Network Provider satisfies the notice and consent criteria of 45 C.F.R. §149.420, by:
 - (1) Providing to the Participant notice that the health care provider is an Out-of-Network Provider, and an estimate of the charges for the covered services; and
 - (2) Obtaining consent from the Participant (or the Participant's Authorized Representative) to be treated and balance billed by the Out-of-Network Provider.
 - b) When the Out-of-Network Provider satisfies the notice and consent requirements, covered services are subject to the provisions of section 2.c., below.

c) Notice and consent requirements described above, do not apply to:

(1) Ancillary Services; and

(2) Covered services provided as a result of unforeseen, urgent medical needs, that arise at the time other covered services are being rendered, regardless of whether the Out-of-Network Provider satisfied the notice and consent requirements.

These covered services are always subject to the provisions of section 2.b.1) above.

c. For all other covered services provided by an Out-of-Network Provider (except as otherwise authorized by CareFirst or stated in this document):

1) If a Participant chooses an Out-of-Network Provider, covered services may be eligible for reduced benefits.

2) All benefits for covered services will be payable to the Participant, or to the Out-of-Network Provider, at the discretion of CareFirst.

3) In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the State of Maryland Department of Health or the non-insuring parent if proof is provided that such parent has paid the Out-of-Network Provider.

4) Out-of-Network Providers are not required to accept the Allowed Benefit as full payment and will collect additional amounts from the Participant up to the provider's actual charge. The Allowed Benefit may be substantially less than the provider's actual charge to the Participant. Therefore, when covered services are provided by Out-of-Network Providers, Participants should expect to pay additional amounts to providers that exceed the Allowed Benefit. The Participant is responsible for the difference between CareFirst's payment and the Out-of-Network Provider's charge.

3. Any copayment, coinsurance, and/or other cost-sharing requirement for services provided by Out-of-Network Providers **will be the same** as the copayment, coinsurance, and/or other cost-sharing requirement stated in this Schedule of Benefits for services provided by In-Network Providers, for the following services:

a. Emergency Services provided by Out-of-Network Providers.

b. Air Ambulance Services provided by Out-of-Network Providers.

c. Non-emergency services provided by Out-of-Network Providers at in-network facilities (including Ancillary Services and services for unforeseen urgent medical needs), except when the Out-of-Network Provider has satisfied the Notice and Consent Requirements of 45 C.F.R. §149.420 (c) through (i), as stated in Note #2. b. 2), above.

- d. Services provided by an Out-of-Network Provider, when the Participant relied on a database, provider directory, or information provided by CareFirst regarding the health care provider's status (through a telephone call or electronic means) which incorrectly indicated that the health care provider was an In-Network Provider for the services received.
4. All cost-share payments made by the Participant for the following services, will contribute towards the in-network deductible and out-of-pocket:
 - a. Emergency Services provided by Out-of-Network Providers.
 - b. Air Ambulance Services provided by Out-of-Network Providers
 - c. Non-emergency services provided by Out-of-Network Providers at in-network facilities (including Ancillary Services and services for unforeseen urgent medical needs), except when the Out-of-Network Provider has satisfied the Notice and Consent Requirements of 45 C.F.R. §149.420 (c) through (i), as stated in Note #2. b. 2), above.
 - d. Services provided by an Out-of-Network Provider, when the Participant relied on a database, provider directory, or information provided by CareFirst regarding the health care provider's status (through a telephone call or electronic means) which incorrectly indicated that the health care provider was an In-Network Provider for the services received.
5. In the event a Participant is a continuing care patient receiving a course of treatment from a provider which is in-network and that provider is terminated, not renewed, or otherwise ends for any reason other than the provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Participant shall be notified in a timely manner and that the Participant has rights to elect continued transitional care from the provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Participant was notified of the provider's termination and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

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

- a. is undergoing a course of treatment for a serious and complex condition from a specific provider,
- b. is undergoing a course of institutional or Inpatient care from a specific provider,
- c. is scheduled to undergo non-elective surgery from a specific provider, including receipt of postoperative care with respect to the surgery,
- d. is pregnant and undergoing a course of treatment for the Pregnancy from a specific provider, or
- e. is or was determined to be terminally ill and is receiving treatment for such illness from a specific provider.

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

6. The physician office visit copay includes the following services, if performed in the office and billed by the physician: radiology, pathology, laboratory, and other diagnostic tests; surgery; allergy shots / serum; and injections / injectables.
7. The following professional services will be paid at the in-network benefit level when rendered at an in-network facility: anesthesia; emergency services; consultations; surgical assistance; and radiology, pathology, laboratory, and other diagnostic tests.
8. If it is verified by the Claims Administrator that a needed service is not available in the network, benefits will be paid at the in-network benefit level. To qualify for this benefit, there must be no In-Network Provider for the needed service within 50 miles from the Participant's residence. A Service Availability Form must be completed and sent to the Claims Administrator.
9. If you are admitted as an inpatient immediately following an out-of-network emergency room visit where you received emergency services, inpatient services rendered during the initial confinement will be paid at the in-network benefit level. Except as stated in the Emergency Services subsection of the Covered Services section of this document, any out-of-network treatment following the initial confinement will be paid as any other covered service, as shown in the Schedule of Benefits.
10. For purposes of determining copay amounts, a Primary Care Provider (PCP) is either a nurse practitioner or a physician practicing in the following disciplines: general practice, family practice, internal medicine, pediatrics, obstetrics / gynecology, or geriatrics. All other physicians are considered specialists, unless otherwise required by applicable law.
11. Any lifetime limit applies to all benefit plan options within the Plan and represents the maximum amount of benefits a Participant is eligible to receive during the entire time the Participant is covered under the Plan.

RETIREE BCBS I PLAN SCHEDULE OF BENEFITS		
DEDUCTIBLE per Plan Year	BLUE CROSS/BLUE SHIELD	MAJOR MEDICAL
Individual	\$100	
Family	None	
<p>The deductible is the amount of eligible expenses you must pay each Plan Year for certain covered services, before the Plan pays the benefit amounts shown in this Schedule of Benefits. The remaining percentage, for which you are responsible, is called coinsurance.</p> <p><u>Individual Coverage:</u> The Participant must meet the individual deductible each Plan Year before benefits begin.</p> <p>The following expenses do not apply to the deductible: copays, Prescription Drug Plan expenses, pre-certification penalties, non-covered services, and charges in excess of the Allowed Benefit.</p>		

RETIREE BCBS I PLAN SCHEDULE OF BENEFITS		
OUT-OF-POCKET MAXIMUM per Plan Year	BLUE CROSS/BLUE SHIELD	MAJOR MEDICAL
Individual	\$2,000	
Family	None	
<p>The out-of-pocket maximum is the maximum dollar amount you are responsible for paying under the Medical Plan during a Plan Year, including the deductible, coinsurance, and copays.</p> <p><u>Individual Coverage:</u> After the individual out-of-pocket maximum is reached, the Plan will pay 100% of the Allowed Benefit for the remainder of the Plan Year.</p> <p>A copay is the flat dollar amount shown in the Schedule of Benefits that you are required to pay for certain covered services. Copays will not be charged after the in-network out-of-pocket maximum has been reached.</p> <p>The following expenses do not apply to the out-of-pocket maximum: Prescription Drug Plan expenses, pre-certification penalties, non-covered services, and charges in excess of the Allowed Benefit.</p>		

Hospital and Other Facility Services ..		Retiree BCBS I Plan
Covered Services	Blue Cross/ Blue Shield	Major Medical
Inpatient Hospital <i>Inpatient hospital or health care facility services are limited to seventy (70) days per inpatient admission</i>	100% of Allowed Benefit Pre-certification required	100% of Allowed Benefit Pre-certification required
Diagnostic Tests, Labs, Radiology, Pathology - Outpatient	100% of Allowed Benefit	100% of Allowed Benefit
Other Radiology & Imaging Services - MRI, MRA, PETScan, CTScan and Nuclear Medicine	100% of Allowed Benefit Pre-certification required	100% of Allowed Benefit Pre-certification required
Emergency Room <i>Copay waived if admitted</i>	\$75 copay, then 100% of Allowed Benefit	\$75 copay, then 100% of Allowed Benefit
Ambulatory Surgical Facility	100% of Allowed Benefit Pre-certification required	100% of Allowed Benefit Pre-certification required
Extended Care Facility / Skilled Nursing Facility <i>Inpatient hospital or health care facility services are limited to seventy (70) days per inpatient admission</i>	Not covered at this level	80% of Allowed Benefit After deductible Pre-certification required
Rehabilitation Facility Inpatient Hospital <i>Inpatient hospital or health care facility services are limited to seventy (70) days per inpatient admission</i>	100% of Allowed Benefit Pre-certification required	80% of Allowed Benefit and \$30 copay After deductible Pre-certification required
Outpatient - Illness	Not covered at this level	80% of Allowed Benefit After deductible
Outpatient - Surgery	100% of Allowed Benefit	100% of Allowed Benefit
Clinic Visit	100% of Allowed Benefit	100% of Allowed Benefit
Occupational Therapy <i>Limited to thirty (30) visits per illness or injury combined with Physical Therapy and Speech Therapy per Plan Year</i>	Not covered at this level	80% of Allowed Benefit After deductible
Physical Therapy <i>Limited to thirty (30) visits per illness or injury combined with Occupational Therapy and Speech Therapy per Plan Year</i>	Not covered at this level	80% of Allowed Benefit After deductible
Speech Therapy <i>Limited to thirty (30) visits per illness or injury combined with Physical Therapy and Occupational Therapy per Plan Year</i>	Not covered at this level	80% of Allowed Benefit After deductible
Renal Dialysis	100% of Allowed Benefit Pre-certification required	80% of Allowed Benefit After deductible Pre-certification required
Respiratory Therapy	Not covered at this level	80% of Allowed Benefit After deductible
Chemotherapy	100% of Allowed Benefit Pre-certification required	80% of Allowed Benefit After deductible

		Pre-certification required
Radiation Therapy	100% of Allowed Benefit Pre-certification required	80% of Allowed Benefit After deductible Pre-certification required
Professional Services		Retiree BCBS I Plan
Covered Services	Blue Cross/ Blue Shield	Major Medical
Home Visits <i>Limited to one (1) visit following childbirth, mastectomy, or testicular surgery</i>	100% of Allowed Benefit	80% of Allowed Benefit After deductible
Diagnostic Tests, Labs, Radiology, Pathology	100% of Allowed Benefit	100% of Allowed Benefit
Other Radiology & Imaging Services - MRI, MRA, PETScan, CTScan and Nuclear Medicine	100% of Allowed Benefit Pre-certification required	100% of Allowed Benefit Pre-certification required
Physician Visit – Telephone Consultation	Not covered at this level	80% of Allowed Benefit After deductible
Physician Visit - Telemedicine (Designated Provider)	\$20 copay, then 100% of Allowed Benefit	Not covered at this level
Physician Visit - Telemedicine (Non-Designated Provider)	Same as any covered service	Same as any covered service
Vision Therapy	Not covered at this level	80% of Allowed Benefit After deductible
Physician Visit - PCP	Not covered at this level	80% of Allowed Benefit After deductible
Physician Visit - Specialist	Not covered at this level	80% of Allowed Benefit After deductible
Anesthesia – Inpatient	100% of Allowed Benefit	80% of Allowed Benefit for services in excess of limitations After deductible
Anesthesia - Outpatient	100% of Allowed Benefit	80% of Allowed Benefit After deductible
Chiropractic Care	Not covered at this level	80% of Allowed Benefit After deductible
Emergency Services in the Emergency Room	100% of Allowed Benefit	80% of Allowed Benefit After deductible
Hyperbaric Oxygen Therapy	Not covered at this level	80% of Allowed Benefit After deductible
Physician Visit – Inpatient <i>Inpatient medical care and surgical services are limited to seventy (70) days per inpatient admission. This limitation is combined with all inpatient admission days Covered Services</i>	100% of Allowed Benefit	80% of Allowed Benefit for services in excess of limitations After deductible
Oral Surgery <i>Benefits are available to the same extent as benefits provided for inpatient or outpatient medical care or surgery</i>	Not covered at this level	80% of Allowed Benefit After deductible

Occupational Therapy <i>Limited to thirty (30) visits per illness or injury combined with Physical Therapy and Speech Therapy per Plan Year</i>	Not covered at this level	80% of Allowed Benefit After deductible
Physical Therapy <i>Limited to thirty (30) visits per illness or injury combined with Occupational Therapy and Speech Therapy per Plan Year</i>	Not covered at this level	80% of Allowed Benefit After deductible
Speech Therapy <i>Limited to thirty (30) visits per illness or injury combined with Physical Therapy and Occupational Therapy per Plan Year</i>	Not covered at this level	80% of Allowed Benefit After deductible
Respiratory Therapy	Not covered at this level	80% of Allowed Benefit After deductible
Renal Dialysis	100% of Allowed Benefit	80% of Allowed Benefit After deductible
Second Surgical Opinion	100% of Allowed Benefit	80% of Allowed Benefit After deductible
Surgery - Inpatient <i>Inpatient medical care and surgical services are limited to seventy (70) days per inpatient admission. This limitation is combined with all inpatient admission days Covered Services</i>	100% of Allowed Benefit After deductible	80% of Allowed Benefit for services in excess of limitations After deductible
Surgery - Outpatient	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Surgery - Physician's Office	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Surgical Assistant – Inpatient <i>Inpatient medical care and surgical services are limited to seventy (70) days per inpatient admission. This limitation is combined with all inpatient admission days Covered Services</i>	100% of Allowed Benefit After deductible	80% of Allowed Benefit for services in excess of limitations After deductible
Surgical Assistant – Outpatient	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Chemotherapy	100% of Allowed Benefit After deductible Pre-certification required	80% of Allowed Benefit After deductible Pre-certification required
Radiation Therapy	100% of Allowed Benefit After deductible Pre-certification required	80% of Allowed Benefit After deductible Pre-certification required
Other Eligible Services		Retiree BCBS I Plan
Covered Services	Blue Cross/ Blue Shield	Major Medical
Acupuncture	Not covered at this level	80% of Allowed Benefit After deductible

Air Ambulance	Not covered at this level	80% of Allowed Benefit After deductible Pre-certification required for non-emergencies only
Ambulance	Not covered at this level	80% of Allowed Benefit After deductible
Allergy Shots / Serum	Not covered at this level	80% of Allowed Benefit After deductible
Allergy Testing	Not covered at this level	80% of Allowed Benefit After deductible
Biofeedback Therapy	Not covered at this level	80% of Allowed Benefit After deductible
Cardiac Rehabilitation	Not covered at this level	80% of Allowed Benefit After deductible
Cleft Lip/ Palate	Same as any covered service	Same as any covered service
Clinical Trials - Patient Costs	Same as any covered service Pre-certification required	Same as any covered service Pre-certification required
Dental Services	Same as any covered service	Same as any covered service
Diabetes Management	Not covered at this level	80% of Allowed Benefit After deductible
Durable Medical Equipment (DME)	Not covered at this level	80% of Allowed Benefit After deductible
Footwear - Diabetic shoes and inserts	Not covered at this level	80% of Allowed Benefit After deductible
Footwear - Orthopedic/Therapeutic Shoes	Not covered at this level	80% of Allowed Benefit After deductible
Gender Affirmation Services	Same as any covered service	Same as any covered service
Habilitative Services	Not covered at this level	80% of Allowed Benefit After deductible
Hearing Aid Fitting and Evaluation	100% of Allowed Benefit	80% of Allowed Benefit After deductible
Hearing Aids for Adults <i>Limited to \$1,000 per hearing-impaired ear every thirty-six (36) months</i>	Not covered at this level	100% of Allowed Benefit
Hearing Aids for a Minor Dependent Child <i>Limited to one (1) hearing aid for each hearing-impaired ear per thirty-six (36) months up to age eighteen (18)</i>	Not covered at this level	100% of Allowed Benefit
Home Health Care <i>Limited to Hospital/ Home Health Agency Forty (40) days per Plan Year</i>	100% of Allowed Benefit After deductible	80% of Allowed Benefit for services in excess of limitations After deductible
Hospice - Bereavement Counseling <i>Limited to fifteen (15) visits following the family member's death per Plan Year</i>	100% of Allowed Benefit	80% of Allowed Benefit

Hospice - Family Counseling <i>Limited to fifteen (15) visits per Plan Year</i>	100% of Allowed Benefit	80% of Allowed Benefit
Hospice - Inpatient Care <i>Benefits are limited thirty (30) days inpatient per lifetime</i>	100% of Allowed Benefit Pre-certification required	100% of Allowed Benefit Pre-certification required
Hospice - Outpatient Care <i>Benefits are limited to one-hundred eighty (180) days inpatient/outpatient combined</i>	100% of Allowed Benefit Pre-certification required	100% of Allowed Benefit Pre-certification required
Hospice - Respite Care <i>Limited to fourteen (14) days per Plan Year</i>	100% of Allowed Benefit	100% of Allowed Benefit
Infusion Therapy	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Injections / Injectables	Not covered at this level	80% of Allowed Benefit
Medical Foods and Nutritional Substances	Not covered at this level	80% of Allowed Benefit After deductible
Medical Supplies	Not covered at this level	80% of Allowed Benefit After deductible
Nutritional Counseling	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Orthotic Device	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Pediatric/Infant Feeding Programs	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Pre-admission Testing	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Private Duty Nursing - Inpatient/ Outpatient	Not covered at this level	80% of Allowed Benefit After deductible
Prosthetic Device	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Pulmonary Rehabilitation	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Sleep Studies - Attended	100% of Allowed Benefit After deductible	100% of Allowed Benefit After deductible
Sleep Studies – Unattended	100% of Allowed Benefit After deductible	100% of Allowed Benefit After deductible
Temporomandibular Joint (TMJ) Disorder - Non-Surgical	Not covered at this level	80% of Allowed Benefit After deductible
Temporomandibular Joint (TMJ) Disorder - Surgical	Not covered at this level	80% of Allowed Benefit After deductible
Transportation and Lodging <i>Limited to \$10,000 per Plan Year</i>	Transportation – 100% of transportation costs Lodging – Up to \$50 per day per Participant Benefit applies when any covered service under the medical Plan is inaccessible within 50 miles of home zip code After deductible	
Urgent Care Center Visit	80% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Walk-In Clinic Visit	100% of Allowed Benefit	80% of Allowed Benefit

	After deductible	After deductible
Wig <i>Limited to one (1) wig up to \$350 per Plan Year</i>	Not covered at this level	80% of Allowed Benefit After deductible
Applied Behavior Analysis (ABA) Services		Retiree BCBS I Plan
Covered Services	IN-NETWORK	OUT-OF-NETWORK
Applied Behavioral Analysis	Same as any covered service	Same as any covered service
Maternity Services		Retiree BCBS I Plan
Covered Services	Blue Cross/ Blue Shield	Major Medical
Genetic Testing (Prenatal)	100% of Allowed Benefit After deductible Pre-certification required	80% of Allowed Benefit After deductible Pre-certification required
Birthing Classes	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Prenatal Care as defined under Women's Preventive Services, as specified by the Patient Protection and Affordable Care Act	100% of Allowed Benefit	100% of Allowed Benefit
Inpatient Hospital – Mother	100% of Allowed Benefit Pre-certification required	100% of Allowed Benefit Pre-certification required
Inpatient Hospital – Newborn	100% of Allowed Benefit Pre-certification required	100% of Allowed Benefit Pre-certification required
Birthing Center	100% of Allowed Benefit Pre-certification required	100% of Allowed Benefit Pre-certification required
Delivery	100% of Allowed Benefit	80% of Allowed Benefit After deductible
Anesthesia	100% of Allowed Benefit	100% of Allowed Benefit
Diagnostic Tests, Labs, Radiology, Pathology	100% of Allowed Benefit	100% of Allowed Benefit
Prenatal and Postnatal Office Visits not billed with delivery	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Pre and Postnatal (Non-Preventive)	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Abortion Care Services	100% of Allowed Benefit	100% of Allowed Benefit
Organ Transplants		Retiree BCBS I Plan
Covered Services	Blue Cross/ Blue Shield	Major Medical
Inpatient Hospital <i>Inpatient medical care and surgical services are limited to seventy (70) days per inpatient admission. This limitation is combined with all inpatient admission days Covered Services</i>	100% of Allowed Benefit Pre-certification required	80% of Allowed Benefit for Covered Services in excess of limitations
Anesthesia	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Transplant Procedure	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Diagnostic Tests, Labs, Radiology, Pathology	100% of Allowed Benefit	100% of Allowed Benefit

Donor Expenses	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Procurement	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Mental Health and Substance Use Disorder Services		Retiree BCBS I Plan
Covered Services	Blue Cross/ Blue Shield	Major Medical
Inpatient Hospital <i>Inpatient medical care and surgical services are limited to seventy (70) days per inpatient admission. This limitation is combined with all inpatient admission days Covered Services</i>	100% of Allowed Benefit Pre-certification required	100% of Allowed Benefit Pre-certification required
Methadone Maintenance	80% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Office Visit	Not covered at this level	80% of Allowed Benefit After deductible
Physician Visit - Telemedicine (Designated Provider)	\$20 copay, then 100% of Allowed Benefit	Not covered at this level
Physician Visit - Telemedicine (Non-Designated Provider)	Same as any covered service	Same as any covered service
Residential Treatment Facility <i>Inpatient medical care and surgical services are limited to seventy (70) days per inpatient admission. This limitation is combined with all inpatient admission days Covered Services</i>	100% of Allowed Benefit Pre-certification required	100% of Allowed Benefit Pre-certification required
Partial Hospitalization	100% of Allowed Benefit After deductible Pre-certification required	80% of Allowed Benefit After deductible Pre-certification required
Inpatient Visits <i>Inpatient medical care and surgical services are limited to seventy (70) days per inpatient admission. This limitation is combined with all inpatient admission days Covered Services</i>	100% of Allowed Benefit After deductible	80% of Allowed Benefit for Covered Services in excess of limitations
Intensive Outpatient Services	100% of Allowed Benefit After deductible Pre-certification required	80% of Allowed Benefit After deductible Pre-certification required
Outpatient Visits	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Outpatient Facility	100% of Allowed Benefit	100% of Allowed Benefit
Psychiatric Testing	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Infertility Services <i>Infertility lifetime limit: \$100,000 for all Medical Plan services and Prescription</i>		Retiree BCBS I Plan

Drugs combined		
Covered Services	Blue Cross/ Blue Shield	Major Medical
Artificial Insemination (AI) <i>Benefits for artificial insemination (AI) and/ or intrauterine insemination (IUI) are limited to six (6) attempts per live birth and up to a lifetime maximum benefit of \$100,000 combined with IVF and Prescription Drugs</i>	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Intra-Uterine Insemination (IUI) <i>Benefits for artificial insemination (AI) and/ or intrauterine insemination (IUI) are limited to six (6) attempts per live birth and up to a lifetime maximum benefit of \$100,000 combined with IVF and Prescription Drugs</i>	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
In-Vitro Fertilization (IVF) <i>Benefits for in-vitro fertilization (IVF) are limited to three (3) attempts per live birth; and a lifetime maximum of \$100,000 combined with AI/IUI and Prescription Drugs</i>	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Gamete Intra-Fallopian Transfer (GIFT) <i>Benefits for (GIFT) are limited to three (3) attempts per live birth; and a lifetime maximum of \$100,000 combined with AI/IUI and Prescription Drugs</i>	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Zygote Intra-Fallopian Transfer (ZIFT) <i>Benefits for (ZIFT) are limited to three (3) attempts per live birth; and a lifetime maximum of \$100,000 combined with AI/IUI and Prescription Drugs</i>	100% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Cryopreservation Storage <i>Limited to twelve (12) months for Participants undergoing imminent fertility treatment or for Participants with Iatrogenic infertility (including gender affirmation surgery) and up to a lifetime maximum benefit of \$100,000 combined with all Medical Plan services and prescription drugs</i>	80% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Preimplantation Genetic Testing (PGT) <i>Limited to a lifetime maximum benefit of \$100,000 combined with all Medical Plan services and prescription drugs</i>	80% of Allowed Benefit After deductible	80% of Allowed Benefit After deductible
Preventive Services A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-		Retiree BCBS I Plan

preventive-care-benefits		
Covered Services	Blue Cross/ Blue Shield	Major Medical
Preventive Service for Adults and Children as specified by the Affordable Care Act	100% of Allowed Benefit	100% of Allowed Benefit
Skin Cancer Screening	100% of Allowed Benefit	100% of Allowed Benefit
Women's Preventive Services, as specified by the Affordable Care Act	100% of Allowed Benefit	100% of Allowed Benefit

Notes:

1. To obtain in-network benefits, a provider must participate in the network at the time services are rendered. Contact the provider or the network before you receive services to verify that the provider participates in the network. Refer to your network directory for a list of In-Network Providers.
2. Claims for covered services rendered by Out-of-Network Providers may be submitted directly to CareFirst by the Out-of-Network Provider, or the Participant may need to submit the claim. In either case, it is the responsibility of the Participant to make sure that all claims are filed on time.
 - a. For Emergency Services provided by an Out-of-Network Provider:
 - 1) All benefits for covered services will be payable directly to the Out-of-Network Provider.
 - 2) In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the State of Maryland Department of Health or the non-insuring parent if proof is provided that such parent has paid the Out-of-Network Provider.
 - 3) The Participant is not responsible for the difference between CareFirst's payment and the Out-of-Network Provider's charge.
 - 4) Benefits for Emergency Services by Out-of-Network Providers are available to the same extent as benefits available for Emergency Services provided by In-Network Providers. See the Schedule of Benefits for details.
 - b. For covered services provided by an Out-of-Network Provider in an in-network facility (including Ancillary Services and Services for unforeseen urgent medical needs):
 - 1) Except when the Out-of-Network Provider satisfies the Notice and Consent Requirements (described below):
 - a) All benefits for covered services will be payable directly to the Out-of-Network Provider.
 - b) In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be

paid directly to the State of Maryland Department of Health or the non-insuring parent if proof is provided that such parent has paid the Out-of-Network Provider.

- c) The Participant is not responsible for the difference between CareFirst's payment and the Out-of-Network Provider's charge.
- d) Benefits for covered services provided by an Out-of-Network Provider in an in-network facility (including Ancillary Services and services for unforeseen urgent medical needs) are available to the same extent as benefits available for covered services provided by In-Network Providers. See the Schedule of Benefits for details.

2) Notice and Consent Requirements

- a) The Out-of-Network Provider satisfies the notice and consent criteria of 45 C.F.R. §149.420, by:

- (1) Providing to the Participant notice that the health care provider is an Out-of-Network Provider, and an estimate of the charges for the covered services; and

- (2) Obtaining consent from the Participant (or the Participant's Authorized Representative) to be treated and balance billed by the Out-of-Network Provider.

- b) When the Out-of-Network Provider satisfies the notice and consent requirements, covered services are subject to the provisions of section 2.c., below.

- c) Notice and consent requirements described above, do not apply to:

- (1) Ancillary Services; and

- (2) Covered services provided as a result of unforeseen, urgent medical needs, that arise at the time other covered services are being rendered, regardless of whether the Out-of-Network Provider satisfied the notice and consent requirements.

These covered services are always subject to the provisions of section 2.b.1) above.

- c. For all other covered services provided by an Out-of-Network Provider (except as otherwise authorized by CareFirst or stated in this document):

- 1) If a Participant chooses an Out-of-Network Provider, covered services may be eligible for reduced benefits.

- 2) All benefits for covered services will be payable to the Participant, or to the Out-of-Network Provider, at the discretion of CareFirst.
 - 3) In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the State of Maryland Department of Health or the non-insuring parent if proof is provided that such parent has paid the Out-of-Network Provider.
 - 4) Out-of-Network Providers are not required to accept the Allowed Benefit as full payment and will collect additional amounts from the Participant up to the provider's actual charge. The Allowed Benefit may be substantially less than the provider's actual charge to the Participant. Therefore, when covered services are provided by Out-of-Network Providers, Participants should expect to pay additional amounts to providers that exceed the Allowed Benefit. The Participant is responsible for the difference between CareFirst's payment and the Out-of-Network Provider's charge.
3. Any copayment, coinsurance, and/or other cost-sharing requirement for services provided by Out-of-Network Providers **will be the same** as the copayment, coinsurance, and/or other cost-sharing requirement stated in this Schedule of Benefits for services provided by In-Network Providers, for the following services:
 - a. Emergency Services provided by Out-of-Network Providers.
 - b. Air Ambulance Services provided by Out-of-Network Providers.
 - c. Non-emergency services provided by Out-of-Network Providers at in-network facilities (including Ancillary Services and services for unforeseen urgent medical needs), except when the Out-of-Network Provider has satisfied the Notice and Consent Requirements of 45 C.F.R. §149.420 (c) through (i), as stated in Note #2. b. 2), above.
 - d. Services provided by an Out-of-Network Provider, when the Participant relied on a database, provider directory, or information provided by CareFirst regarding the health care provider's status (through a telephone call or electronic means) which incorrectly indicated that the health care provider was an In-Network Provider for the services received.
4. All cost-share payments made by the Participant for the following services, will contribute towards the in-network deductible and out-of-pocket:
 - a. Emergency Services provided by Out-of-Network Providers.
 - b. Air Ambulance Services provided by Out-of-Network Providers
 - c. Non-emergency services provided by Out-of-Network Providers at in-network facilities (including Ancillary Services and services for unforeseen urgent medical needs), except when the Out-of-Network Provider has satisfied the Notice and Consent Requirements of 45 C.F.R. §149.420 (c) through (i), as stated in Note #2. b. 2), above.

- d. Services provided by an Out-of-Network Provider, when the Participant relied on a database, provider directory, or information provided by CareFirst regarding the health care provider's status (through a telephone call or electronic means) which incorrectly indicated that the health care provider was an In-Network Provider for the services received.
5. In the event a Participant is a continuing care patient receiving a course of treatment from a provider which is in-network and that provider is terminated, not renewed, or otherwise ends for any reason other than the provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Participant shall be notified in a timely manner and that the Participant has rights to elect continued transitional care from the provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Participant was notified of the provider's termination and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

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

- a. is undergoing a course of treatment for a serious and complex condition from a specific provider,
- b. is undergoing a course of institutional or Inpatient care from a specific provider,
- c. is scheduled to undergo non-elective surgery from a specific provider, including receipt of postoperative care with respect to the surgery,
- d. is pregnant and undergoing a course of treatment for the Pregnancy from a specific provider, or
- e. is or was determined to be terminally ill and is receiving treatment for such illness from a specific provider.

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

6. Benefit limits include both in-network and out-of-network services.
7. The following professional services will be paid at the in-network benefit level when rendered at an in-network facility: anesthesia; emergency services; consultations; surgical assistance; and radiology, pathology, laboratory, and other diagnostic tests.
8. If it is verified by the Claims Administrator that a needed service is not available in the network, benefits will be paid at the in-network benefit level. To qualify for this benefit, there must be no In-Network Provider for the needed service within 50 miles from the Participant's residence. A Service Availability Form must be completed and sent to the Claims Administrator.
9. If you are admitted as an inpatient immediately following an out-of-network emergency room visit where you received emergency services, inpatient services rendered during the initial confinement will be paid at the in-network benefit level. Except as stated in the Emergency Services subsection of the Covered Services section of this document, any

out-of-network treatment following the initial confinement will be paid as any other covered service, as shown in the Schedule of Benefits.

10. Any lifetime limit applies to all benefit plan options within the Plan and represents the maximum amount of benefits a Participant is eligible to receive during the entire time the Participant is covered under the Plan.

COVERED SERVICES

IMPORTANT NOTE REGARDING THE AFFORDABLE CARE ACT (ACA)

For purposes of the Affordable Care Act, the Plan has elected the Utah Benchmark Plan, as defined by the ACA, as the basis for coverage of Essential Health Benefits.

Abortion Care Services – Benefits are available for abortion care services.

Acupuncture - Benefits are available for acupuncture to induce surgical anesthesia and for therapeutic purposes.

Ambulance - Benefits are available for ground, air, and water transportation by a legally authorized, licensed private ambulance or municipal ambulance to the nearest facility that can provide the appropriate care for patients whose medical condition prevents safe transportation by any other means.

Ground, air, and water ambulance services are covered only under the following circumstances:

- Emergency ground ambulance transportation to the nearest hospital when the ambulance is equipped with appropriate emergency medical supplies and equipment, and any other form of transportation would be medically contraindicated or harmful to the patient;
- Non-emergency ground ambulance services from one facility to another facility to provide more appropriate care;
- Non-emergency ground ambulance services to and from a facility to provide appropriate care;
- Non-emergency ground ambulance services from a facility to a patient's residence when the patient requires skilled monitoring during transport by a licensed health care practitioner;
- In exceptional circumstances, emergency air and water ambulance services to the nearest facility equipped to treat the patient's condition, when one of the following occur:
 - The patient's condition requires immediate and rapid ambulance transport that cannot be provided by ground ambulance;
 - The patient's condition is such that the time needed to transport by land poses a threat to the patient's health;
 - The point of pick-up is inaccessible by land vehicle;
 - Great distances or other obstacles, such as traffic or weather conditions, are involved if the patient were to be transported by ground ambulance.

Anesthesia - Benefits are available for the cost and administration of anesthesia.

Applied Behavior Analysis (ABA) – Benefits are available for ABA services, as defined in the Definitions section.

Birthing Center - Benefits are available for a licensed or certified institution that meets the following criteria:

- a. Provides 24-hour-a-day nursing service by or under the direction of Registered Nurses and Certified Nurse Midwives;
- b. Staffed, equipped, and operated to provide care for patients during an uncomplicated pregnancy, delivery and the immediate postpartum period; and

- c. Provides care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a hospital.

Cardiac Rehabilitation Program - Benefits are available for Cardiac Rehabilitation Programs for a heart attack, heart surgery, or a diagnosis of angina pectoris when services are rendered by a hospital-based Cardiac Rehabilitation Program or a program that is coordinated with a hospital.

Chiropractic Care - Benefits are available for detecting and correcting structural imbalance, distortion, misalignment, and incomplete or partial dislocation of or in the vertebral column. Eligible expenses do not include maintenance care or palliative treatment.

Cleft Lip / Palate – Benefits are available for inpatient or outpatient services for cleft lip or cleft palate or both and are covered as follows:

- a. Oral Surgery
- b. Orthodontics
- c. Otologic, audiological and speech/language treatment

Benefits will be provided for inpatient or outpatient expenses arising from orthodontics, oral surgery, otologic, audiological, and speech/language treatment for cleft lip or cleft palate or both.

Clinic Visit - Benefits are available for a clinic visit, which is a facility charge for an outpatient visit to a hospital-based physician.

Clinical Trials – Patient Costs - Benefits are provided to qualified individuals for the routine patient costs of items and services furnished in connection with participation in an approved clinical trial.

A qualified individual must meet the following conditions:

- a. The individual must be eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition; and
- b. Either:
 - 1. The referring health care professional is an In-Network Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
 - 2. The individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

If one or more In-Network Providers is participating in a clinical trial, the Plan may require that a qualified individual participate in the trial through such an In-Network Provider if the provider will accept the individual as a participant in the trial.

Routine patient costs include all items and services consistent with the coverage provided under this Plan that is typically covered for a qualified individual who is not enrolled in a clinical trial.

Routine patient costs do not include:

- a. The investigational item, device, or service, itself;
- b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

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

- a. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - 1. The National Institutes of Health.
 - 2. The Centers for Disease Control and Prevention.
 - 3. The Agency for Health Care Research and Quality.
 - 4. The Centers for Medicare & Medicaid Services.
 - 5. A cooperative group or center of any of the entities described in (1) through (4) above or the Department of Defense or the Department of Veterans Affairs.
 - 6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - 7. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:
 - i. to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
 - ii. assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- c. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Dental Services – Benefit for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care will be provided to a Participant under the following circumstances:

- a. If the Participant is:
 - 1) Seven (7) years of age or younger, or developmentally disabled,
 - 2) An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Participant, and
 - 3) An individual for whom a superior result can be expected from dental care provided under general anesthesia.
- b. Or if the Participant is:
 - 1) Seventeen years of age or younger,
 - 2) An extremely uncooperative, fearful, or uncommunicative individual,
 - 3) An individual with dental needs of such magnitude that treatment should not be delayed or deferred, and

- 4) An individual for whom lack of treatment can be expected to result in severe oral pain, significant infection, loss of multiple teeth, or other serious oral or dental morbidity.
- c. Or, if the Participant has a medical condition that requires admission to a hospital or ambulatory surgical facility and general anesthesia for dental care.
- d. Benefits for general anesthesia and associated hospital or ambulatory facility charges are restricted to dental care that is provided by:
 - 1) A fully accredited specialist in pediatric dentistry,
 - 2) A fully accredited specialist in oral and maxillofacial surgery, and
 - 3) A dentist who has been granted hospital privileges.
- e. This provision does not provide benefits for general anesthesia and associated hospital or ambulatory facility charges for dental care rendered for temporomandibular joint disorders.
- f. This provision does not provide benefits for which the general anesthesia is provided.

Diabetes Management - Benefits are available for outpatient diabetes self-management training and educational services, including medical nutritional therapy, that the Participant's treating physician or other appropriately licensed health care provider, or a physician who specializes in the treatment of diabetes, certifies are medically necessary for the treatment of:

- a. Insulin-using diabetes;
- b. Noninsulin-using diabetes; or
- c. Elevated blood glucose levels induced by pregnancy.

The services must be provided through a program supervised by an appropriately licensed, registered, or certified health care provider whose scope of practice includes diabetes education or management.

Diagnostic Services - Benefits are available for diagnostic services obtained on an inpatient or outpatient basis. They are tests or procedures ordered by a Physician or other professional provider because of specific symptoms. Diagnostic services must be directed toward determining a definite condition or disease and can include:

- a. X-ray and other radiology services;
- b. Laboratory and pathology services; or
- c. Cardiographic, encephalographic and radioisotope tests.

Durable Medical Equipment (DME) - Any equipment designed for repeated use and which is medically necessary for the treatment of an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. DME shall also include wheelchairs, hospital beds, respirators and other such items as determined by the Claims Administrator:

Benefits for DME are available for the lesser of the rental charges or the purchase price. The DME must be:

- a. Primarily and customarily used to serve a medical purpose and generally is not useful to a person in the absence of illness or injury;
- b. Appropriate for use in the home;
- c. Prescribed by a Physician; and
- d. Consistent with the diagnosis.

Standard DME is equipment including braces, devices or supplies which provides the basic therapeutic or functional purpose necessary for the Participant's condition. Deluxe DME is equipment which has features not necessitated by the patient's medical condition.

Benefits for the initial services and supplies for eyeglasses or contact lenses, and hearing aids and their fitting, are available when required due to illness or accidental bodily injury occurring while the patient is covered under this Plan. Benefits for contact lenses include one (1) pair per benefit period for Participants diagnosed with keratoconus.

In addition, benefits may be provided for one pair of eyeglasses or contact lenses required as a result of and directly related to intraocular surgery. Examples of surgeries for which such benefits may be allowed include cataract surgery, cornea transplant and scleral buckling. Benefits would not be provided in cases such as strabismus surgery in which extraocular muscle work is performed.

Emergency Services – Medical evaluation, examination, and treatment to stabilize a Participant experiencing acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

With respect to an Emergency Medical Condition:

- a. Emergency Services include post-stabilization services provided by Out-of-Network Providers, as part of outpatient observation or an inpatient stay related to the Participant's Emergency Medical Condition, unless:
 - 1) The attending emergency physician or Treating Health Care Provider determines that the Participant is able to travel using non-medical transportation (non-ambulance) or non-emergency medical transportation (non-emergency ambulance) to an available in-network facility located within a reasonable travel distance, taking into consideration the Participant's medical condition; and
 - 2) The health care provider providing the post-stabilization services to the Participant, satisfies the Notice and Consent Requirements, stated above in the Notes of the Schedule of Benefits, and the Notice and Consent satisfies the following additional criteria:
 - a) If the post-stabilization services are being provided by an Out-of-Network Provider in an in-network facility, the written notice must include:
 - (1) A list of In-Network Providers at the Emergency Facility who are able to provide the post-stabilization services needed by the Participant; and
 - (2) Notification that the Participant may be referred, at the Participant's option, to an In-Network Provider;

- b) If the post-stabilization services are being provided at an out-of-network emergency facility, the written notice must include the good faith estimated amount that the Participant may be charged for the services provided by the Out-of-Network Provider; and
- c) The Treating Health Care Provider or attending emergency physician has determined that the Participant, or the Participant's Authorized Representative are in a condition to receive the notice and provide informed consent to receive the services from the Out-of-Network Provider.

Extended Care Facility or Skilled Nursing Facility - Any hospital services and supplies available on an inpatient basis are available for a confinement in an Extended Care Facility or Skilled Nursing Facility.

Family Counseling (except for Retiree BCBS I Plan) – Benefits are available for counseling for families when they experience a stressful event that may strain family relationships, such as financial hardship, divorce and other marital issues, or the death or aging of a loved one.

Family Planning – Benefits are available for:

- a. Contraceptive counseling, including instruction on Fertility Awareness–Based Methods rendered by a licensed health care provider.
- b. Contraceptive exam, insertion and removal: benefits are available for the insertion or removal, and any Medically Necessary examination associated with the use of a contraceptive device/Prescription Drug, approved by the FDA for use as a contraceptive, and prescribed by a Health Care Provider.

Footwear – Benefits are available for the following custom-made footwear:

- Orthopedic shoes;
- Diabetic shoes and inserts, designed to reduce the risk of skin breakdown; and
- Orthotic foot inserts that are custom-molded and casted.

Replacement of footwear that is medically necessary due to normal use or physiological change in the patient's condition is covered.

Gender Affirmation Services - JHU's intent is to align with WPATH recommendations for gender affirmation services in each of the following categories:

- **Behavioral Health:** Coverage for the assessment, diagnosis, and treatment of Gender Dysphoria by a licensed mental health professional. This would also include assessments and referrals for surgery & preparation for hormone therapy. Diagnosis of Gender Dysphoria is required for gender affirmation surgeries.
- **Non-Surgical Gender Affirmation Treatment:** Coverage for feminizing/masculinizing hormone therapies, which will induce physical changes that are more congruent with a patient's gender identity; includes puberty suppression.

Surgical Gender Affirmation Treatment: Feminizing/masculinizing surgical procedures. This includes "top" surgical procedures (breast/chest) and "bottom" (genital) surgical procedures. Gender affirming surgeries will require the following:

- Pre-certification
- A single letter of referral or recommendation from a qualified health care provider (minimum of Master’s degree equivalent) with training and experience in medical care for gender affirmation patients
- Persistent and well-documented gender dysphoria
- Capacity to make fully informed decisions and to consent for treatment
- Age of majority (age 18)
- If significant medical or mental health concerns are present, they must be reasonably well controlled

Reconstructive and Complementary Procedures: Non-surgical feminizing/masculinizing procedures. These reconstructive surgeries are considered medically necessary for someone diagnosed with Gender Dysphoria, not cosmetic, and therefore may be covered by health plans. Requirements for reconstructive and complementary procedures include:

- Persistent and well-documented gender dysphoria
- Capacity to make fully informed decisions and to consent for treatment
- Age of majority (age 18)
- If significant medical or mental health concerns are present, they must be reasonably well controlled

Preventing Future Infertility / Preventative Care: Coverage for ongoing preventative care for transgender health, including fertility, depending on the changes to the body due to hormone therapy

- Fertility benefits will be provided according to the overall policy
- Storage will be covered for 12 months

Domestic Travel and Lodging: Travel and lodging for any needed service or procedure that is related to gender dysphoria and not available within 50 miles of a Participant.

Benefit	Procedure/ Service	Details
Mental Health	Assessment of gender identity and diagnosis of gender dysphoria	Consultation with psychologist, psychiatrist, social worker, mental health counselor, marriage and family therapist, nurse, or family medicine with specific training in behavioral health and counseling. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.
	Counseling regarding options for gender identity and possible medical interventions	Mental health professional’s attention or referrals to facilitate a process in which clients explore various options, with the goals of finding a comfortable gender role and expression, and becoming prepared to make a fully informed decision about available medical interventions.
	Assess, diagnose, and discuss treatment for coexisting mental health concerns	Professional services; could also include pharmacotherapy or referrals to other mental health care qualified professionals. Screening of history and coexisting mental health concerns. Make reasonably sure that the gender dysphoria is not secondary to other diagnoses. Identify other co-morbidities.
	Asses eligibility, readiness for hormone	Mental health professionals need to provide prompt attentive evaluation, with the goal of alleviating

	therapy	patient's gender dysphoria and providing them with appropriate medical services.
	Referral for feminization/masculinizing hormone therapy	<p>Referral letter for feminizing/masculinizing hormone therapy to include:</p> <ol style="list-style-type: none"> 1. The client's general identifying characteristics; 2. Results of the client's psychosocial assessment, including any diagnoses; 3. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy; 4. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date; 5. A statement that informed consent has been obtained from the patient; 6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish
	Assess eligibility, prepare and refer for surgery	Mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared.
	Referral for surgery	<p>One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty)</p> <p>Two referrals – from qualified mental health professionals who have independently assessed the patient-- are needed for genital surgery. The first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient.</p>
	Psychotherapy for pre- and post-transition and co-morbid conditions	<p>Psychotherapy sessions prior and post hormone therapy or surgery. Family therapy or support for family members; individual, couple, family and group psychotherapy</p> <p>Mental health professionals can provide support and promote interpersonal skills and resilience, can help members express themselves in a way that is congruent with their gender identity, and assist members when coming out to family and community.</p> <p>This benefit should be offered in line with benefits</p>

		offered to general employee population.
	Follow up to previously seen GID patients	Mental health professionals may work with clients and their families at different times and for various issues throughout the life cycle.
	On-line therapy	Online or e-therapy has been shown to be particularly useful for people who have difficulty accessing competent in-person psychotherapeutic treatment and who may experience isolation and stigma.
Hormone therapy (pre- and post-surgery)	Medication professional monitoring Laboratory test Hormones and other drugs	Medical consultations including specialists (Endocrinologist, cardiologist, oncologist), nurse practitioners, physician assistants, and primary care physicians, telemedicine; reproductive options counseling. Risk assessment for hormone-related adverse effects Baseline laboratories and risk assessment screenings prior to hormone therapy Hormones and other drugs, including hormone replacement in case of oophorectomy or orchiectomy. Hormone maintenance prior gonad removal
Hormone Therapy: MtF	Hormones drugs and others, including hormone replacement in case of orchiectomy Hormone maintenance prior gonad removal	Oral estrogen, transdermal estrogen, anti-androgens, (Spironolactone, Cyproterone acetate), GnRH (e.g., goserelin, buserelin, triptorelin); 5-alpha reductase inhibitors (finasteride and dutasteride); Progestins micronized progesterone.
Hormone Therapy: FtM	Hormones drugs and others, including hormone replacement in case of oophorectomy Hormone maintenance prior gonad removal	Testosterone, oral, transdermal and parenteral (IM), buccal and implantable preparations; progestins and GnRH to assist menstrual cessation; Compounded hormones.
Puberty suppression	Hormones drugs and others	GnRhH analogs for puberty suppression
Hormone Therapy: MtF	Venous thromboembolic	Monitoring exams and comorbidities treatment
Associated Risks	Liver disease / Hepatotoxicity Gallstones Weight gain Lipid Disorders Cardiovascular cerebrovascular disease Hypertension	Monitoring exams and comorbidities treatment

	Prolactinoma Type 2 Diabetes	
Hormone Therapy: MtF	Sexual Dysfunction	Follow the standard used for the rest of the population in the current medical plan, e.g. 6-8 doses/ 30 days.
Associated Risks	Breast Cancer Polycythemia	Cancer screening and treatment Monitoring exams and comorbidities treatment
Hormone Therapy: FtM	Weight gain Acne Androgenic alopecia Sleep Apnea Hepatic dysfunction and malignancies Lipid disorders Destabilization of psychiatric disorders Osteoporosis, cardiovascular, hypertension, Type 2 Diabetes Ovarian and endometrial Cancer Sexual dysfunction Birth Control	Monitoring exams and comorbidities treatment. Monitoring exams and comorbidities treatment. Cancer screening and treatment Follow the standard used for the rest of the population in the current medical plan, e.g. 6-8 doses/ 30 days. Follow the standard used for the rest of the population in the current medical plan.
Breast/Chest (MtF)	Augmentation mammoplasty Breast Prosthesis	Breast prostheses implantation, and or lipofilling technique shall be covered, prosthesis capsularfibrosis, rupture, etc. Cover as part of reconstructive and complementary services, up to insured amount Breast prostheses supply as part of the reconstructive procedure.
Surgery (MtF)	Amputation of penis – complete Urethromeatoplasty w/ partial excision of distal urethral segment Plastic repair of introitus Adjacent tissue transfer of rearrangement for genitalia Vaginoplasty	Unlimited coverage

	<p>constructed with colon segment Clitoroplasty Labioplasty Penile skin inversion Construction of vagina with graft Bilateral orchiectomy Coloproctostomy (low pelvic anastomosis) Other unlisted procedure, female genital system for male to female</p>	
<p>Genital Surgery (FtM)</p>	<p>Mastectomy (simple, complete) Redundant skin removal Mastectomy scar revision Subcutaneous mastectomy Creation of male chest Nipple/Areolar Reconstruction Hysterectomy Salpingo- oophorectomy Vaginectomy Urethroplasty Colpectomy (removal of vagina) w/o hysterectomy Colpectomy (removal of vagina) w/ hysterectomy Phalloplasty Second stage phalloplasty Modified abdominoplasty as part of phalloplasty Urethroplasty, one stage reconstruction of male anterior urethra Urethroplasty reconstruction of urethra Scrotoplasty, complicated Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump and/or cylinders and/or reservoir Plastic operation of penis for injury – for glans formation</p>	<p>Unlimited coverage</p>

	<p>Insertion of testicular expanders</p> <p>Replacement of tissue expander with permanent prosthesis</p> <p>Prosthesis testicular insertion</p> <p>Insertion of penile prosthesis; non-inflatable, semi-rigid</p> <p>Insertion of penile prosthesis; inflatable, self-contained</p> <p>Removal or replacement of non- inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis</p> <p>Insertion of inflatable (multi-component) penile prosthesis, including placement of pump, cylinders, and/or reservoir</p> <p>Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or cylinders and/or reservoir</p> <p>Metoidioplasty procedure</p> <p>Formation of direct or tubed pedicle w/ or w/o transfer</p> <p>Free skin flap w/ microvascular anastomosis</p> <p>Free fascial flap w/ microvascular anastomosis</p> <p>Nerve graft, single strand, arm or leg up to 4 cm length</p> <p>Nerve graft, single strand, arm or leg more than 4 cm length</p> <p>Suture of major peripheral nerve, arm or leg, except sciatic including transposition</p> <p>Split graft, trunk arms, legs, first 100 sq. cm or</p>	
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	<p>less Split graft, trunk, arms, legs, each additional 100 sq. cm Electrolysis or laser hair removal of skin graft for genital surgery</p>	
<p>Voice and communication therapy MtF FtM</p>	<p>Voice and communication therapy provided by health professionals</p>	<p>Speech-language pathologists, speech therapists, and speech-voice clinicians. Treatment may involve individual and/or group sessions Unlimited coverage, following the same conditions already provided by the current carrier</p>
<p>Other Non-Genital / Non-breast reconstructive Surgery (MtF)</p>	<p>Reduction Thyroid Chondroplasty (Thyroid Reduction) Tracheal Shave Suction-assisted lipoplasty of the waist Rhinoplasty Facial bone reduction Face lift Blepharoplasty Laryngoplasty /Vocal Cord (Voice Surgery) Liposuction (Contour modeling of the waist) Lipofilling (Breast, body, face) Gluteal augmentation (implants/lipofilling) Permanent Hair Removal Hair Implants Hair cranial prosthesis (Wigs)</p>	<p>Unlimited coverage</p>
<p>Other Non-Genital Non-breast reconstructive Surgery (FtM)</p>	<p>Liposuction to reduce fat in hips, thighs, buttocks Lipofilling Male chest reconstruction Pectoral implants Abdominoplasty Facial bone reconstruction Other electrolysis or laser hair removal Laryngoplasty/ Vocal Cord (Voice Surgery) rare</p>	<p>Unlimited coverage</p>
<p>Reversal Treatment</p>	<p>Treatment covered in case a member decides to</p>	<p>Unlimited coverage.</p>

	reverse procedures	
Prevention of Future Infertility	Sperm preservation Oocyte preservation Assisted Reproductive Technology¹, artificial insemination, IVF (Embryo development and transfer) Cryopreservation of fertilized embryos Surrogate parenting (Host uterus) Donor Eggs Donor Sperm	Provide egg, sperm, embryo freezing, ART up to lifetime maximum of fertility policy; Allow storage for 12 months
Preventive Care: Trans Male	Provide preventive care needs related to their gender of birth (Breast, and feminine reproductive organs remnants tissues)	Covered in line with general medical coverage without restriction based on gender.
Preventive Care: Trans Female	Provide preventive care needs related to their gender of birth (Prostate, and masculine reproductive organs remnants tissues)	Covered in line with general medical coverage without restriction based on gender.
Travel and Lodging	Coverage within the US for referred patients	Coverage \$150 per day up to \$10,000 USD per service only within the US; following same standard for other conditions such as cancer or transplants
Centers of Excellence	Recommended Centers of Excellence, with travel/lodging coverage when the carriers do not partner with health vendors in the patient's area	Prioritize Center of Excellence utilization Coverage \$150 per day up to \$10,000 USD only within the US; following same standard for other conditions such as cancer or transplants, only within the US

Gender Reassignment – Benefits are available for gender reassignment surgery and hormone therapy for the treatment of gender dysphoria.

Benefits are not available for cosmetic surgery or reversal of gender reassignment surgery.

Gene Therapy- Benefits are available for **Medically Necessary gene therapy and related services.**

Genetic Testing and Counseling (except for Retiree BCBS I Plan) – In addition to coverage specified under Preventive Services, benefits are available for genetic testing and counseling to identify individuals at risk for future disorders and to predict the prognosis of diagnosed disease and the treatment response.

Habilitative Services – Benefits are available for habilitative services for Participants with congenital or genetic birth defects or developmental delays that hinder a Participant's ability to

function. Treatment must help the Participant keep, learn, or improve skills and functioning for daily living. Services include occupational therapy, physical therapy, and speech therapy.

Habilitative services are not subject to the benefit limits of other therapy services.

Benefits are not available for services received from early intervention programs, school systems or government agencies.

Hearing Aids – Benefits are available for hearing aids for children under age 18. In addition, benefits are available for services related to the dispensing of hearing aids, such as the assessment exam, evaluation, and fitting.

Home Health Care - To receive Home Health Care benefits, the Participant's condition must necessitate Skilled Care such that he would have required hospital or extended care facility confinement if Home Health Care benefits had not been available. The patient must be under the direct care of a Physician and the patient's Physician must develop a plan of treatment with a hospital or Home Health Care agency which defines the services the patient is to receive at home.

The Home Health Care agency must be licensed to provide nursing and other therapeutic services. Any single visit up to four hours by a member of a Home Health Care agency will equal one Home Health Care visit.

Covered Home Health Care services provided by the Home Health Care agency include:

- a. Part-time or intermittent nursing care, by a Registered Nurse (RN) or a Licensed Practical or Vocational Nurse (LPN/LVN);
- b. Part-time or intermittent home health aide or homemaker services for the patient only;
- c. Occupational, speech, audiological, physical, and respiratory therapies provided by a Home Health Care agency;
- d. Social work, performed by a certified or licensed Social Worker (if licensing is not required by the state in which the work is performed, the Social Worker must have at least a master's degree in social work) to help the patient and family cope with the illness; and
- e. Nutrition services by a Registered Dietician.

Home Health Care Exclusions:

- a. Custodial care;
- b. Services or supplies not included in the home health care plan;
- c. Any period during which the Participant is not under the care of a Physician; and
- d. Those services or supplies listed under the Exclusions and Limitations section.

Home Visits – Benefits are available for one home visit scheduled to occur within 24 hours after discharge (and one additional visit if prescribed by the attending provider) for the following procedures:

- a. Childbirth, for a mother and newborn child who remain in the hospital for less than 48 hours after an uncomplicated vaginal delivery or for less than 96 hours after an uncomplicated cesarean section, if rendered by a registered nurse with at least one year of experience in maternal and child health nursing or in community health nursing with an emphasis on maternal and child health;

- b. Mastectomy, on an outpatient basis or with an inpatient hospitalization of less than 48 hours following the surgery; and
- c. Surgical removal of a testicle, on an outpatient basis or with an inpatient hospitalization of less than 48 hours following the surgery.

For a patient who remains in the hospital for at least the number of hours stated above, one home visit is covered if prescribed by the attending provider.

An attending provider includes a physician, certified nurse midwife, or pediatric nurse practitioner.

Hospice Care - Benefits are available to terminally ill patients with a life expectancy of six months or less.

Inpatient Hospice Care - All inpatient services covered while a Participant is confined in a hospital are also covered under Hospice Care. All treatment rendered to a Participant admitted to a Hospice Care Program must be under the direction of a Physician.

Outpatient Hospice Care - Benefits will be provided for Hospice Care services rendered in the patient's home by members of the Hospice Care team when the services are billed by a Hospice Provider. The following outpatient Hospice Care services are covered when rendered by members of a Hospice Care team:

- a. Nursing care by a Registered Nurse (RN) or Licensed Practical/Vocational Nurse (LPN/LVN);
- b. Patient care provided by home health aides or homemaker services;
- c. Visits by Medical Social Workers;
- d. Visits by Physical and Respiratory Therapists;
- e. Rental of durable medical equipment such as hospital beds, respirators, oxygen tents, crutches and wheelchairs when billed by the Hospice Provider;
- f. Medically necessary surgical and medical supplies;
- g. Drugs and medicines billed by the Hospice Provider;
- h. Nutritional counseling by a Registered Dietician;
- i. Family counseling;
- j. Group or individual bereavement counseling for family members during the specified period following the patient's death; and
- k. Respite care – Temporary care provided to the terminally ill participant to relieve the family caregiver from the daily care of the participant.

Hospital Inpatient - Benefits are available for the following services when a Participant is admitted to a hospital:

- a. Room and board and general nursing care in a semi-private room (2 or more beds), and a special care unit;
- b. Private room accommodations, if medically necessary;
- c. Use of operating, delivery, and treatment rooms and equipment;
- d. Prescribed drugs and medications administered in the hospital;
- e. Charges related to unreplaced blood, blood plasma and expanders including the processing, collection, and storage of blood;
- f. Anesthesia and its administration;
- g. Oxygen and its administration;
- h. Dressings, supplies, casts and splints;
- i. Diagnostic services; and

- j. Therapy services.

Hospital Outpatient - Any hospital services and supplies available on an inpatient basis are also available on an outpatient basis for:

- a. X-rays, laboratory services and diagnostic tests;
- b. Outpatient surgery and anesthesia;
- c. Emergency care; and
- d. Therapy services.

Independent Freestanding Emergency Facility - A health care facility that is geographically separate and distinct, and licensed separately from a hospital under applicable law, and which provides Emergency Services.

Infertility - Diagnostic evaluation and testing to determine the cause of infertility is covered. Benefits are also available to Employees, Dependent Spouses, and Domestic Partners for services and supplies related to the treatment of infertility or which assist in achieving pregnancy, including infertility counseling, drugs, hormone therapy, and tests performed during a monthly cycle.

The following assisted reproductive technology procedures are covered: artificial insemination (AI), intra-uterine insemination (IUI), in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT).

For opposite-sex couples, use of the egg and sperm of the Participant and his or her partner is required. Egg and sperm banks and other donor expenses are covered under special circumstances.

For same-sex female couples, use of the egg of the Participant or her partner is required. Egg and sperm banks and other donor expenses are covered under special circumstances.

Benefits are available for cryopreservation, storage, thawing of eggs, sperm, or embryos related to infertility treatment. This also includes preimplantation genetic testing.

Infertility treatment is not covered if the cause of infertility is voluntary sterilization.

Infusion Therapy - Medically referred treatment for parenteral infusion of antibiotics, chemotherapy, total parenteral nutrition, and other infusion therapies in an outpatient facility, a Physician's office, or the patient's residence. Covered services include:

- a. Medical care for the patient receiving home infusion therapy via central venous line or standard intra-venous route;
- b. Nutritional and other infusion therapies, including hydration, antibiotics, chemotherapy, pain management, and certain blood products; and
- c. Related nursing care and supplies.

Injectables - Benefits are available for FDA-approved injectable drugs requiring administration by a physician that are not eligible for benefits under the Prescription Drug Plan.

Mastectomy Related Services – Covered benefits:

- a. Coverage for reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast including augmentation mammoplasty, reduction mammoplasty, and mastopexy;
- b. Breast prostheses prescribed by a physician for a Participant who has undergone a mastectomy and has not had breast reconstruction;
- c. Physical complications from all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the Participant;
- d. Home Health Care services, as stated in the Home Health Care services subsection of this Description of Covered Services; and
- e. Reconstructive 3D nipple areola tattooing by designated providers determined by the Group.

Maternity Services - Benefits are available for maternity services for covered Employees, Spouses, and Dependent Children. Hospital, surgical, and medical benefits are available on an inpatient and outpatient basis for the following maternity services:

- Routine prenatal and postnatal care;
- Delivery;
- Treatment for complications of a pregnancy; and
- Postpartum home visit to assess mother and newborn by a Home Health Care agency.

Benefits are available for one birthing course per pregnancy.

Inpatient hospital services in connection with childbirth, for the mother or newborn child(ren), including routine nursery care of the newborn child(ren), are available for:

- a. A minimum of:
 - 1) Forty-eight (48) hours following an uncomplicated vaginal delivery; or
 - 2) Ninety-six (96) hours following an uncomplicated cesarean section.
- b. Up to four (4) additional days of routine nursery care of the newborn child(ren) when the Participant is required to remain in the hospital for Medically Necessary reasons.

Medical Foods – Benefits are available for medical foods that are specially formulated to be consumed or administered under strict medical supervision and are intended for the dietary treatment of a disease or condition for which nutritional requirements are established as medically necessary.

Medical Services and Supplies - Medical care is the non-surgical treatment a Participant receives from a Physician for an illness or injury, including:

- Physician's inpatient visits;
- Care by a surgeon and, at the same time, care by another Physician, provided the Physicians are treating two separate conditions;
- Consultations, excluding routine staff consultations required by hospital rules;
- Home and office visits;
- Charges related to unreplaced blood, blood plasma, and expanders, including the processing, collection, and storage of blood;
- Allergy tests and shots;
- Oxygen;

- Diabetic equipment and supplies, except supplies covered by the Prescription Drug Plan; and
- Pre-term labor monitoring devices.

Mental Health and Substance Use Disorder Services – Benefits are available for inpatient and outpatient care for mental health conditions and substance use disorders, including:

- Individual, family, and group therapy;
- Psychiatric tests;
- Detoxification;
- Residential Crisis Services;
- Methadone maintenance treatment;
- Psychological and neurological testing for diagnostic purposes;
- Residential treatment facilities;
- Partial hospitalization;
- Intensive outpatient services; and
- Other services related to the diagnosis.

Methadone Maintenance - Benefits are available for methadone maintenance treatment, a comprehensive treatment program that involves the long-term prescribing of methadone as an alternative to the opioid on which a patient was dependent. Benefits are also available for other drug therapies that treat opioid dependence.

Newborn Services - Benefits are available for inpatient newborn care, including expenses related to circumcision of the newborn, on the same basis as for any other eligible expense, provided the baby is enrolled as a Participant within 30 days of birth.

Benefits are also available for universal hearing screening of newborns provided by a hospital before discharge or in an office or other outpatient setting.

Nutritional Counseling - In addition to coverage specified under Preventive Services, benefits are available for Medically Necessary Professional Nutritional Counseling, including Medical Nutritional Therapy services.

Oral Surgery – Benefits are available only for the following procedures:

- Surgical procedures required to correct injuries of the jaw, cheeks, lips, tongue, roof, and floor of the mouth;
- Surgical removal of impacted teeth;
- Surgery involving accessory sinuses, salivary glands, and ducts;
- Excision of tumors and cysts of the jaw, cheeks, roof, and floor of the mouth when pathological examination is required;
- Excision of exostosis of the jaw and hard palate when not related to the fitting of dentures;
- Extraoral incision and drainage of abscesses;
- Maxillomandibular dysfunction; and
- Extraction of teeth due to a medical diagnosis related to radiation therapy.

Organ Transplants – Benefits are available for services, supplies, and treatment in connection with human-to-human organ and tissue transplant procedures, subject to the following conditions:

- a. Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
- b. When the recipient is covered under this Plan, the Plan will pay the recipient's covered expenses related to the transplant;
- c. When the donor is covered under this Plan, the Plan will pay the donor's covered expenses related to the transplant, provided the recipient is also covered under this Plan. Covered expenses incurred by each person will be considered separately for each person;
- d. Expenses incurred by the donor who is not covered under this Plan, according to eligibility requirements, will be covered expenses to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this Plan. The donor's expense shall be applied to the recipient's maximum benefit. In no event will benefits be payable in excess of the maximum benefit available to the recipient;
- e. If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogeneic). Coverage will also be provided for treatment and storage costs of the marrow, up to the time of reinfusion; and
- f. Charges incurred for follow-up care, including immunosuppressant therapy.

Travel Allowance: The following services are covered if the Transplant Program Provider is located 50 or more miles from the recipient's home:

- a. Air transportation is limited to the cost of one round-trip coach airfare to the Transplant Program Provider for the recipient and a travel companion;
- b. Transportation using a motor vehicle will be paid in accordance with the current IRS allowance per mile for medical travel;
- c. Hotel accommodations for the recipient if released to an outpatient facility for post-surgical care from the Transplant Program Provider, up to the maximum shown in the Schedule of Benefits;
- d. Hotel accommodations for a travel companion to remain in the immediate area during all or a portion of the duration of the recipient's treatment plan, up to the maximum shown in the Schedule of Benefits; and
- e. Daily meals and other reasonable and necessary services or supplies for the recipient and a travel companion, up to the maximum shown in the Schedule of Benefits.

Transplant Program Provider is the Physician performing the transplant and/or the hospital in which the transplant is performed.

Organ transplant procedures, including complications from any such procedure, services or supplies related to any such procedure, such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, **except** for the following procedures:

- a. Heart; combined heart and lung; single lung; double lung; lobar lung; kidney, kidney/pancreas; pancreas; cornea; liver; bone; small bowel in pediatric patients; small bowel/liver; multivisceral; skin (for grafting or for any other medically necessary purposes);
- b. Autologous bone marrow for:
 - 1) Non-Hodgkin's lymphoma;
 - 2) Hodgkin's lymphoma;
 - 3) Primitive neuroectodermal tumors (PNET);

- 4) Pediatric and Adult acute lymphocytic leukemia in first or subsequent remission;
- 5) Acute non-lymphocytic leukemia in first or subsequent remission;
- 6) Germ cell tumors;
- 7) Multiple myeloma;
- 8) Amyloidosis;
- 9) Acute myelogenous leukemia;
- 10) Initial treatment of high-risk Ewing sarcoma;
- 11) Recurrent or refractory Ewing's sarcoma as salvage therapy of chemosensitive Waldenstrom macroglobulinemia;
- 12) Initial treatment of high-risk neuroblastoma and recurrent or refractory neuroblastoma;
- 13) Disseminated POEMS (polyneuropathy-organomegaly-endocrinopathy-M protein-skin lesions) syndrome.

c. Allogeneic bone marrow for:

- 1) Aplastic anemia;
- 2) Acute lymphoid leukemia (ALL);
- 3) Severe combined immunodeficiency (SCID);
- 4) Wiskott-Aldrich syndrome;
- 5) Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease);
- 6) Chronic myelogenous leukemia (CML);
- 7) Neuroblastoma Stage III or IV in children;
- 8) Homozygous beta thalassemia (thalassemia major);
- 9) Hodgkin's lymphoma;
- 10) Non-Hodgkin's lymphoma;
- 11) Myelodysplastic syndromes;
- 12) Lysosomal storage disorders (mucopolysaccharidosis, Gaucher's disease, Hunter's syndrome, Hurler's syndrome, Sanfilippo syndrome, Maroteaux-Lamy syndrome, mucopolipidosis, lipidosis, and metachromatic leukodystrophy);
- 13) Sickle-cell anemia;
- 14) Myeloproliferative disorders;
- 15) Chronic lymphocytic leukemia (CLL);
- 16) Small lymphocytic lymphoma (SLL).

Under the Organ Transplant benefit, the following services are not covered:

- a. Transportation, lodging, and other charges for a travel companion other than to accompany the recipient to and from the Transplant Program Provider;
- b. Charges in connection with the Travel Allowance that are not related to your travel to and from the Transplant Program Provider, except for charges for your treatment while at the Transplant Program Provider;
- c. Charges for the repair or maintenance of a motor vehicle;
- d. Personal expenses incurred for the maintenance of your or your travel companion's residence. Examples of these are childcare costs, house-sitting costs, or kennel charges;
- e. Reimbursement of any wages lost by you or your travel companion;
- f. The services and medical expenses incurred by a donor (except as specified above) as a result of such transplant procedure; and
- g. Donor screening of the general population.

Orthotic Devices – Benefits are available for the purchase and fitting of orthotic devices, which are rigid or semi-rigid supportive devices (such as back, knee, and foot braces) that restrict or eliminate motion for a weak or diseased body part. Replacement of an orthotic device that is medically necessary due to normal use or physiological change in the patient’s condition is covered.

Pediatric and Infant Feeding Programs – Benefits are available for pediatric intensive feeding programs, consisting of an inter-disciplinary team (e.g., behavioral therapist, occupational therapist, physician, registered dietitian, and speech language pathologist/therapist), to treat complex feeding and swallowing disorders in infants and children. Feeding programs are covered only for the following conditions:

- a. Inability or refusal to eat;
- b. Severe difficulty swallowing;
- c. Choking, gagging, or vomiting when eating;
- d. Dependence on tube feedings or difficulty weaning from a gastric feeding tube (G-tube);
- e. Failure to thrive; and
- f. Severe gastroesophageal reflux.

Pre-Admission Testing - The Plan pays the Allowed Benefit for pre-admission x-rays and laboratory tests required in connection with a scheduled hospital admission or outpatient procedure. Benefits are available if the hospital or physician postpones or cancels the admission or outpatient procedure, but no benefits are payable if the Participant postpones or cancels the hospital admission or outpatient procedure.

Prescription Drugs - See Chapter 3 for pharmacy-dispensed Prescription Drug Benefits.

Benefits are available for under the medical benefits of the Plan, for Prescription Drugs dispensed in the office/place of service of a health care provider, as follows:

- Benefits are available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a health care provider, and dispensed in the office/place of service of a health care provider.
- Injectable Prescription Drugs that require administration by a health care provider.
- Allergenic extracts (allergy sera).
- Immunosuppressant maintenance drugs when prescribed for a covered transplant.

Immunizations for foreign travel.

Preventive Services – In compliance with the Affordable Care Act, benefits for preventive services are provided as follows:

Preventive Services for Adults and Children

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF);

- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive Services can be found at:
www.healthcare.gov/coverage/preventive-care-benefits

Women's Preventive Services – With respect to women, coverage is available for additional preventive care and screenings as provided for in the HRSA's Women's Preventive Services Guidelines.

A description of Women's Preventive Services can be found at:
www.healthcare.gov/coverage/preventive-care-benefits

The following services are not covered:

- Services or supplies for the diagnosis or treatment of a suspected or identified disease;
- Examinations while hospital-confined;
- Services not identified and billed as part of a routine physical examination;
- Services not performed by a Physician or under his or her direct supervision; or
- Pre-marital or employment examinations.

Private Duty Nursing – Private duty nursing is Skilled Nursing Care that is not rendered in a hospital or Skilled Nursing Facility. When ordered by a physician, benefits are available for inpatient (**covered for the Retiree BCBS I Plan only**) and outpatient private duty nursing. Private duty nursing is not covered if rendered by the same nurse for more than one shift per day, or by a nurse who is the patient's family member or who normally resides in the patient's home. Inpatient private duty nursing is not covered (**for the Retiree Core PPO and Retiree LiUNA BU Network Plans**).

Prosthetic Devices

- a. Benefits for Prosthetic Devices except for prosthetic leg(s), arm(s) or eye(s), are available as follows:
 - 1) Medically Necessary Prosthetic Devices
 - 2) Supplies and accessories necessary for effective functioning of a covered Prosthetic Device.
 - 3) Repairs or adjustments to Medically Necessary Prosthetic Devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device.
 - 4) Replacement of covered Prosthetic Devices when repairs or adjustments fail and/or are not possible.
 - 5) Repair of covered Prosthetic Devices.
- b. Benefits for Prosthetic leg(s), arm(s) or eyes, are available as follows:
 - 1) Coverage shall be provided for Prosthetic Devices which replace, in whole or in part, a

- leg, an arm or an eye.
- 2) Coverage includes:
 - a) Components of prosthetic leg, arm or eye; and
 - b) Repairs to prosthetic leg, arm or eye.
 - 3) Requirements for Medical Necessity for coverage of a prosthetic leg, arm or eye will not be more restrictive than the indications and limitations of coverage and medical necessity established under the Medicare Coverage Database.

c. Limitations:

- 1) Benefits for the repair, maintenance or replacement of a covered Prosthetic Device require authorization.
- 2) Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating, and checking of equipment.
- 3) Coverage of repair costs is limited to adjustment required by normal wear or by a change in the Participant's condition and repairs necessary to make the Prosthetic Device serviceable. Repair will not be authorized if the repair costs exceed the market value of the Prosthetic Device.
- 4) Replacement coverage is limited to once every two (2) benefit years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the Device on the part of the Participant or of a family member are not covered.

Pulmonary Rehabilitation - Benefits are provided for a pulmonary rehabilitation program for patients with chronic respiratory impairments. Components of the multidisciplinary program include exercise training; education; occupational, physical, respiratory, and nutritional therapies; and behavior and psychological counseling. Pulmonary rehabilitation is considered medically necessary:

- a. in conjunction with a lung volume reduction surgery protocol;
- b. post-lung transplant surgery, or;
- c. for patients with moderate to severe chronic pulmonary diseases who remain symptomatic despite optimal medical management.

Repatriation of remains – Benefits are available for the transportation of a Participant's bodily remains back to their area of residence, in the event of an illness or injury that results in death, for which treatment of the illness or injury would have been or was covered by the Plan.

Second Surgical Opinion - Benefits are available for a second opinion on the necessity of a specific surgical procedure. The second opinion is voluntary, but if elected, must be given by a board-certified specialist who, by reason of the Physician's specialty, qualifies the Physician to make such an opinion.

Sleep Studies – Benefits are available for attended sleep studies performed in an approved freestanding or hospital sleep center and for in-home unattended sleep studies for certain medical diagnoses related to sleep disorders.

Skin Cancer Screening

Surgery - Inpatient and outpatient surgical services are covered for the following procedures:

- Surgery, when performed by a Physician or other professional provider;
- Assistant at surgery;
- Treatment of fractured or dislocated bones;
- Reconstructive (non-cosmetic) surgery;
- Abortion;
- Surgical treatment of Morbid Obesity, including related pre- and post-surgical office visits;
- Voluntary sterilization for men, including sterilization reversals;
- Voluntary sterilization for women is covered under Preventive Services, including sterilization reversals;

The following guidelines apply to surgical procedures:

Assistant Surgeon Fees - The amount eligible will be based on 20% of the Allowed Benefit for the covered surgical procedure.

Co-Surgery Fees - If two or more surgeons work together as primary surgeons for the same surgical procedure, benefits for all surgeons will not exceed the Allowed Benefit for that procedure.

Multiple Surgical Procedures - If two or more surgical procedures are performed through the same incision, benefits for the primary procedure will be based on 100% of the Allowed Benefit and all other eligible procedures will be based on 50% of the Allowed Benefit.

Note: Reconstructive surgery is covered only to restore bodily function or correct deformity resulting from non-cosmetic surgery, an accidental bodily injury, or a congenital defect.

Surrogacy – Benefits are available for services for surrogate motherhood only when the surrogate or gestational carrier is a Participant. Benefits are available to the same extent as benefits provided for any other Participant.

Telemedicine provided by Non-Designated Telemedicine Providers with Telephone Consultation:

- a. Benefits are available for the use of interactive audio, audio-only telephone, video, or other electronic media for the purpose of diagnosis, consultation, or treatment of the participant at a site other than the site where the participant is located (“Telemedicine Services by Non-Designated Telemedicine Providers”).
- b. Benefits for Telemedicine Services are available for services appropriately provided by Non-Designated Providers, to the extent stated in the Schedule of Benefits.
- c. Telemedicine Services by Non-Designated Telemedicine Providers do not include an electronic mail message, or facsimile transmission between a health care provider and a Participant.

Telemedicine provided by Designated Telemedicine Providers with Telephone Consultation:

- a. Benefits are available for the use of interactive audio, audio-only telephone, video, or other electronic media for the purpose of diagnosis, consultation, or treatment of the participant at a site other than the site where the participant is located (“Telemedicine Services by Designated Telemedicine Providers”).
- b. Benefits for Telemedicine Services are available for services appropriately provided by Designated Providers, to the extent stated in the Schedule of Benefits.
- c. Telemedicine Services by Designated Telemedicine Providers do not include an electronic mail message, or facsimile transmission between a health care provider and a Participant.

Telephone Consultation – Benefits are available for evaluation and management services rendered by a physician to an established patient via a telephone call.

Temporomandibular Joint Disorder (TMJ) - Diagnostic evaluation and testing are covered. Benefits are available for the non-surgical treatment of TMJ for medically necessary appliances and medical or dental care. Surgical treatment for a medical diagnosis related to TMJ is payable as shown in the scheduled of benefits.

Therapy Services – Benefits are available for individual therapy on an inpatient or outpatient basis, including:

- a. Biofeedback Therapy
- b. Chemotherapy
- c. Hyperbaric Oxygen Therapy
- d. Occupational Therapy – to restore bodily function lost due to an illness, injury, or surgical procedure. Eligible expenses do not include maintenance care or palliative treatment.
- e. Physical Therapy – to restore bodily function lost due to an illness, injury, or surgical procedure. Physical therapy includes aquatic therapy when rendered by an approved physical therapist in a physical therapy setting. Eligible expenses do not include maintenance care or palliative treatment.
- f. Radiation Therapy
- g. Renal Dialysis
- h. Respiratory Therapy – the medical treatment of a diseased lung, including non-surgical efforts directed at maintaining, improving, or restoring lung function. Respiratory therapy can be grouped into four major categories: oxygen therapy, aerosol therapy, physical therapy, and mechanical aids to lung inflation.
- i. Speech Therapy – to restore speech lost or impaired due to an illness, injury, surgical procedure, or major congenital anomalies that affect speech. Speech therapy is not covered for language dysfunctions or articulation errors such as stuttering, lisps, or tongue thrust.
- j. Vision Therapy – Therapy to modify different aspects of visual function for patients with eye movement disorders.

Travel costs related to covered services – Benefits for the travel costs related to Covered Services are available, as follows:

- 1. Travel benefits are available when:
 - a. A treatment option is not available to the Participant- within 50 miles from the Participant’s home.

- b. Travel is associated with or related to all covered services under the Plan.
 - c. Covered Services must be provided by a licensed practitioner, in a state where the services can be lawfully provided.
2. Reasonable and necessary costs of lodging and transportation for the Participant and travel companion to and from the Participant's home and place of treatment and which is not reimbursed or paid by another party.
- a. Covered transportation costs are limited to ground and/or air travel reimbursement from Participant's home to and from place of treatment:
 - 1) Ground transportation includes personal vehicle (mileage), parking and tolls, taxis, ride share services, metro, bus, train, and shuttle services.
 - 2) Air transportation via commercial flight limited to coach class only and including reasonable baggage and seating selection fees.
 - 3) Train and bus ticket fares limited to coach class.
 - b. Covered lodging benefits are limited to lodging costs when traveling to receive treatment and include hotel, short-term rentals, or corporate apartment rentals.
3. Benefits under this section are available to the Participant-patient and one (1) companion.

Urgent Care Center Visits – Benefits are available for urgent care center visits to treat illnesses and injuries that are not life-threatening but require prompt medical attention.

Vision (the Retiree LiUNA BU Network Only Plan) - Benefits are available for routine vision examinations to correct refractive errors .

Walk-In Clinic Visits – Benefits are available for retail walk-in clinic visits to treat minor, unscheduled, non-emergency and non-urgent illnesses and injuries, and to receive certain immunizations.

Wigs - Benefits are available for Medically Necessary wigs (hair prostheses) when prescribed by a health care provider.

LIMITATIONS AND EXCLUSIONS

Benefits are not available under the Medical Plan for the following:

Adoption

Blood Processing - Processing, collection, or storage of blood billed by an independent laboratory.

Commission of a Crime - Charges caused or contributed to by a Participant committing or attempting to commit an assault, felony, or participating in an illegal occupation, or actively participating in a violent disorder or riot. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Actively participating does not include being at the scene of a violent disorder or riot while performing his or her official duties. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a medical condition (including both physical and mental health conditions).

Cosmetic Surgery

Counseling – Spiritual, marital (**excluded for Retiree BCBS I Plan**), or financial counseling.

Dental – Treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue, or alveolar processes. Benefits are available as specified under Dental Services.

Diagnostic Inpatient Care - Inpatient care primarily for diagnostic purposes, speech or occupational therapy, or while the participant is confined primarily for rest, custodial or domiciliary care. This exclusion does not apply to Hospice Care.

Durable Medical Equipment (DME) - Charges for the difference in cost between the standard and deluxe models of durable medical equipment.

Exams and related services, and completion of forms, required solely for non-medical purposes- Exams and related services, and completion of forms, required solely for employment, pre-employment screening, insurance, foreign travel, travel requirements, school, camp admissions/scouting programs, participation in sports activities (sports physicals), pre-adoption, adoption, pre-foster parenting, foster parenting, admission to old age home, driving license including commercial driving license, handicapped tag documentation, immigration and naturalization, marriage, prison, disability examination, FMLA verification, Workers' Compensation, attorney forms, or attendance for issue of medical certificates.

Excess Charges - Charges in excess of the Allowed Benefit.

Experimental or Investigational – Services that are determined to be experimental or investigational for research, except as specified under Clinical Trials (Patient Costs).

Family Counseling – Family counseling, except as specified under Hospice Care (**excluded for Retiree BCBS I Plan**).

Foot Care - Routine care of the foot, including removal of corns, calluses, and toenails (except for the partial removal of a nail with removal of part or all of its matrix), unless related to a diabetes diagnosis.

Foreign Medical Care - Drugs, procedures, services, supplies, or treatments rendered or received in person, by mail, or otherwise outside the United States, if the purpose of such travel or communication is to obtain or receive such drug, procedure, service, supply, or treatment.

Genetic Testing and Counseling – Genetic testing and counseling, except as specified under Preventive Services (**excluded for Retiree BCBS I Plan**).

Government Facility - Treatment in a facility owned or operated by the United States or any state or local government unless the Participant is legally obligated to pay.

Hair Loss - Treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a physician, except for wigs.

Home Blood Pressure Monitoring

Holistic or Homeopathic Medicine

Human Growth Hormone Therapy – Refer to the Prescription Drug Plan for covered services and exclusions.

Insertion of Breast Implants - Insertion of breast implants, unless in connection with a mastectomy, or any procedure or related series of procedures whereby breast implants are removed and replaced with new implants.

Insurance or Employment Examinations

Maintenance Care - Services or activities that seek to prevent disease, prolong life, or promote health of an asymptomatic person who has reached the maximum level of improvement and whose condition is resolved or stable.

Myotherapy

Newborn Care - Newborn care for children of a Dependent child.

Non-Covered Services – Services, supplies, or treatment related to non-covered services or complications arising from such non-covered services.

Not Legally Required to Pay - Charges that the Participant is not legally required to pay or that would not have been incurred if no coverage had existed. This exclusion does not apply if a claim is from the Veterans Administration under Title 38 of the U.S. Code for treatment of a veteran not having a service-connected disability.

Non-Medical Services - charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the health care provider or his/her staff.

Not Medically Necessary or Recommended – Services or supplies that are determined not to be medically necessary for the medical care, diagnosis, or treatment of an injury or illness; or charges for any service, treatment, or supply not recommended by a physician.

Obesity – The treatment of obesity, except as specified under Preventive Services.

Oral Nutritional Supplements – Foods, usually liquefied and high in caloric content, that supplement normal eating and promote weight gain.

Palliative Treatment

Patient Education Programs

Personal Hygiene - Personal hygiene, convenience, or personal comfort items such as, but not limited to, vaporizers, air conditioners, humidifiers, air filters, first aid items, bathing / toilet accessories, elevators, stair and van lifts, whirlpools, physical fitness equipment and programs, and other non-medical supplies or equipment.

Personal Injury Protection - Personal Injury Protection (PIP), sometimes called No-Fault First Party Benefits, is a type of mandatory automobile insurance coverage that is used to pay, among other things, medical bills to individuals who are injured in a motor vehicle accident, regardless of who was at fault. Mandatory PIP benefit amounts vary by state. This Plan will deny any claim for medical services or supplies rendered to a Participant, up to the minimum amount of PIP coverage mandated by law in the state of residence, or up to the actual amount of PIP coverage, whichever is greater, whether or not the Participant properly asserts his rights under his automobile insurance coverage.

Private Room - Private room charges beyond the amount normally paid for a semi-private room.

Professional Sports – Treatment or services received as a result of an accidental injury incurred while engaging in a professional sporting event for wage or profit, on an individual or group basis.

Relative Giving Services - Services or supplies rendered by the Participant, the Participant's spouse, or the children, brothers, sisters, parents, or grandparents of either the Participant or the Participant's spouse.

Replacement - Replacement costs of durable medical equipment, orthotic devices, or prosthetic devices resulting from malicious damage, culpable neglect, or wrongful disposition of the equipment or device by the Participant.

Self-help - Educational services, hypnotism, biofeedback, or any type of self-help, goal-oriented, or behavior modification therapies, such as to lose weight or quit smoking, except as specified under Preventive Services.

Services Before or After Coverage - Charges incurred prior to the date an Employee or a Dependent becomes a Participant under this Plan, or charges incurred after the date an Employee or a Dependent is no longer a Participant under this Plan.

Sexual Impairment – Treatment of sexual impairment or inadequacies that are not related to organic disease.

Surrogacy – Services for surrogate motherhood or gestational carriers are not available unless the surrogate mother or gestational carrier is a Participant.

Temporary Dental Appliances – Limited to occlusal guards and orthopedic repositioners, including those provided for the correction of TMJ.

Testing – Personality, IQ, or emotional testing.

Timely Filing – Initial claims received by the Claims Administrator later than one year after the date the treatment or service (on which the claim is based) is rendered or otherwise provided.

Transportation - Transportation expenses, unless specified under Covered Services.

Travel costs related to Covered Services - Meals, tobacco, alcohol, drugs, phone charges, recreation expenses, or other personal expenses; transportation of any form in any class except economy or coach class; limousine or private car services; and expenses reimbursed by another source.

Vision - Routine vision examinations (**for Participants not enrolled in the Retiree LiUNA BU Network Only Plan**), eyeglasses, or contact lenses to correct refractive errors and related services, including surgery performed to eliminate the need for eyeglasses for refractive errors (i.e. radial keratotomy or LASIK), except as specified under Durable Medical Equipment. This exclusion does not apply to benefits for contact lenses for the treatment of keratoconus.

War or Act of War - Treatment of a condition resulting from war or an act of war, declared or undeclared, or an injury sustained or illness contracted while on duty with any military service for any country and illness or injuries sustained in political unrest situations, such as a riot, while traveling on business and when traveling internationally into countries under a “travel warning” by the U.S. State Department.

Weekend Admission - Inpatient hospital admissions occurring on a Friday or Saturday in conjunction with a surgical procedure scheduled to be performed during the following week. A Sunday admission will be eligible only for procedures scheduled to be performed early Monday morning. This exclusion does not apply to necessary medical admissions requiring immediate attention or to emergency surgical admissions.

Workers' Compensation Law – Treatment of an illness or injury arising out of or in the course of any employment for wage or profit for which the Participant is entitled to indemnify under the terms of any Workers' Compensation Law or similar law. This applies whether or not the Participant has declined participation under such law, unless the Participant is a proprietor, partner, or executive corporate officer Employee.

CHAPTER 3

PRESCRIPTION DRUG BENEFITS

The Prescription Drug Claims Administrator is Capital Rx, whom you may contact for questions regarding your Prescription Drug Plan. The Prescription Drug Plan maintains a nationwide network of pharmacies. Capital Rx's customer service may be reached at 1-844-306-4674, or you may access their website at www.cap-rx.com.

Benefits are provided for generic and brand name prescription drugs as follows.

**PRESCRIPTION DRUG PLAN
SCHEDULE OF BENEFITS**

**RETIREE CORE PPO PRESCRIPTION PLAN
RETIREE LIUNA BU NETWORK ONLY PRESCRIPTION PLAN
RETIREE BCBS I PRESCRIPTION PLAN**

All eligible expenses under the Medical Plan and the Prescription Drug Plan apply to the out-of-pocket maximum. After it is reached, the Plan will pay a 100% benefit for the remainder of the Calendar Year.

Please refer to the Medical Plan for the applicable deductible and out-of-pocket maximum amounts.

The following expenses do not apply to the out-of-pocket maximum: non-covered drugs and charges in excess of the maximum contracted price.

Infertility drugs lifetime maximum (Medical and Prescription Drug combined): \$100,000	Copay per Prescription	
	RETAIL 30-day supply	MAIL SERVICE 90-day supply
Generic Drugs	\$10.00 copay	\$25.00 copay
Preferred Brand Name Drugs	20% coinsurance Minimum \$30 Maximum \$45	20% coinsurance Minimum \$75 Maximum \$112.50
Non-Preferred Brand Name Drugs	25% coinsurance Minimum \$60 Maximum \$110	25% coinsurance Minimum \$150 Maximum \$250
Specialty Generic Drugs	\$10.00 copay	\$25.00 copay
Specialty Preferred Drugs	20% coinsurance Minimum \$30 Maximum \$45	20% coinsurance Minimum \$75 Maximum \$112.50
Specialty Non-Preferred Brand Name Drugs	25% coinsurance Minimum \$60 Maximum \$110	25% coinsurance Minimum \$150 Maximum \$250

<p>Over-the-Counter (OTC) Drugs, devices, and supplies, and FDA-approved generic drugs, chemoprevention drugs, vaccines, and Nicotine Replacement Therapies (NRT), as specified by the Affordable Care Act</p> <p>A description of OTC Drugs and vaccines can be found at: www.healthcare.gov/coverage/preventive-care-benefits</p> <p>A description of FDA-approved contraceptive methods can be found at: https://www.healthcare.gov/coverage/birth-control-benefits/</p> <p>A description of chemoprevention drugs can be found at: healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/cancer/talk-with-a-doctor-if-breast-or-ovarian-cancer-runs-in-your-family</p> <p>A description of FDA-approved quit smoking medications and NRT's can be found at: smokefree.gov/explore-medications</p>	<p>100% benefit</p>
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Notes:

1. Eligible prescriptions will automatically be filled with a generic drug if available. If a generic drug is not available, you will pay the applicable brand name copay.
2. If a generic drug is available and you choose to purchase a brand name drug, you will pay the brand name copay, plus the difference in cost between the brand name drug and the generic drug.
3. If a generic drug is available and you choose to purchase a brand name drug, and your prescribing physician instructs to "Dispense as Written", you will pay the applicable brand name copay, plus the difference in cost between the brand name drug and the generic drug.

Generic Drug - A generic drug is a prescription that by law must have the same chemical composition and come in the same strength and dosage form as a specific brand name prescription drug. Generic versions of brand name drugs that are recommended by Capital Rx are reviewed and approved by the FDA (Food & Drug Administration). This ensures that quality generic medications are used, maximizing your prescription benefits. If you choose the generic drug, you will always pay the lowest copay.

Brand Name Drug - A brand name drug is any approved drug a particular pharmaceutical company has the exclusive right to produce and sell. Over time, companies can lose the patents on particular drugs, opening up the market to generic equivalents. Generic drug equivalents may become available at any time.

Preferred Brand Name Drug - A preferred brand name drug is a brand name drug that is on Capital Rx's Formulary List. Capital Rx has a panel of physicians and pharmacists that meets regularly to identify and review prescription drugs that provide the highest therapeutic and economic value. By choosing drugs on this list, your physician helps keep the cost of prescription drugs affordable. Preferred brand name drugs are subject to change at any time. Your physician may contact Capital Rx to obtain information on the formulary. Using formulary drugs saves you money, but you are not required to use them.

Non-Preferred Brand Name Drug - A non-preferred brand name drug is a brand name drug that is not on Capital Rx's formulary list. Brand name drugs are expensive to create. If you choose a non-preferred brand name drug, you will pay the highest copay.

Over-the-Counter Drugs – The Affordable Care Act requires that the Plan provide benefits for a comprehensive list of preventive services. Included in this list are several over-the-counter drugs. If your physician recommends that you take one of the drugs on this list, benefits will be provided under this Plan. You must obtain a prescription from your physician for the OTC drug and present it to the pharmacist. The pharmacist will fill your prescription with no copay. A list of these services and OTC drugs, can be found at: www.healthcare.gov/coverage/preventive-care-benefits

The Affordable Care Act also requires that the Plan provide benefits for preventive services for women. Benefits include a comprehensive list of generic and OTC birth control medications and devices approved by the FDA. If your physician recommends that you take one of the drugs or use one of the devices on this list, benefits will be provided under this Plan. You must obtain a prescription from your physician for the generic or OTC drug or device and present it to the pharmacist. The pharmacist will fill your prescription with no copay. If your physician prescribes a brand name drug, you will be required to pay the appropriate copay. A list of FDA-approved contraceptive methods can be found at:

<https://www.healthcare.gov/coverage/birth-control-benefits/>

When you present your prescription drug card to an in-network pharmacy, your cost for a prescription or a refill will be the brand name or generic prescription copay as indicated in the Schedule of Benefits. For maintenance prescription drugs, you can obtain a larger quantity by using the Mail Service Prescription Drug Program, saving you trips to the pharmacy and prescription copay expenses.

The patient should discuss the prescription alternatives with his doctor to determine if a lower cost alternative is available and appropriate for his condition. The patient and the doctor should determine the treatment plan that is most appropriate for the condition. In some cases, this may mean the patient will pay the higher copay.

SPECIAL PRESCRIPTION DRUG PROGRAMS

Prior Authorization – Specialty drugs require Prior Authorization before coverage can be confirmed. This is a process through which your physician confirms with a Caremark pharmacist that your prescription is appropriately prescribed for safety, effectiveness for your stage of illness, and medical necessity. The CaremarkConnect® specialty team will work with your physician to perform this review when you order a specialty prescription. CaremarkConnect® can be reached at 800-237-2767. If your specialty prescription does not meet the criteria for approval, you and your physician will receive a letter from Caremark instructing you how you may file an appeal.

STEP THERAPY OR FAIL FIRST PROTOCOL

Prescription Guidelines means the limited list of Prescription Drugs issued by the Plan for which providers, when writing, and pharmacists, when filling prescriptions, must obtain prior authorization from the Plan, the quantity limits that the Plan has placed on certain drugs and Prescription Drugs which require Step Therapy. The Plan may change the requirements contained in the guidelines periodically without notice to Participants. The Plan may change the requirements contained in the guidelines periodically without notice to Participants. A copy of the Prescription Guidelines is available to the Participant upon request.

Step Therapy or Fail-First Protocol means a protocol established by The Plan that requires a Prescription Drug or sequence of Prescription Drugs to be used by a Participant before a Prescription Drug ordered by the Participant's provider is covered.

Step Therapy Drug means a Prescription Drug or sequence of Prescription Drugs required to be used under a Step Therapy or Fail-First Protocol.

Supporting Medical Information, with respect to Step Therapy or Fail-First Protocol, means:

1. A paid claim for a Participant from The Plan or
2. A Pharmacy record that documents that a prescription has been filled and delivered to the Participant or representative of the Participant; or,
3. Other information mutually agreed to by The Plan and the provider prescribing the Step Therapy Drug.

Specialty Pharmacy Copay Assistance Program

Under Capital Rx's specialty pharmacy copay assistance strategy, certain specialty pharmacy drugs are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the participant's out-of-pocket maximum. Although the cost of the program drugs will not be applied towards satisfying a participant's out-of-pocket maximum, the cost of the eligible drugs may be reimbursed by the manufacturer. Copays for certain specialty medications may be set to the maximum of the current plan design or any available manufacturer-funded copay assistance may vary and are dependent upon the current plan design and the availability of manufacturer-funded assistance. To learn which drugs may be impacted by this strategy, call Capital Rx at 1-888-832-2779.

COVERED SERVICES

The Prescription Drug Plan pays up to the supply shown in the Schedule of Benefits for all the medicine your doctor requests on the original prescription or refill. The Plan also pays for the following:

- **Breast Cancer** – Breast cancer risk-reducing medications, as specified by the Affordable Care Act.
- **Contraceptives** – Oral contraceptives, contraceptive devices, and other injectable drugs used for contraception that require a prescription, and generic or over-the-counter contraceptive drugs or devices as specified by the Affordable Care Act.
- **HIV Pre-Exposure Prophylaxis (PrEP) Prescription Drugs**
- **Human Growth Hormones**
- **Immunization Vaccines** – Immunization vaccines for adults and children, as specified by the Affordable Care Act.
- **Infertility Drugs and Agents**
- **Insulin**
- **Insulin Supplies**
- **Legend Drugs** – A pharmaceutical product that cannot be obtained legally without a physician's prescription.
- **Prenatal Vitamins**

- **Smoking Cessation Products** – Smoking cessation products, in addition to FDA-approved tobacco cessation medications as specified by the Affordable Care Act.
- **Syringes (other than insulin)**
- **Spacers**
- **Weight Loss Drugs**

EXCLUSIONS

In addition to the Exclusions and Limitations and other provisions of the Plan, benefits are not available under the Prescription Drug Plan for the following:

- **Abortifacients**
- **Administration** – Charges for administering a drug or giving an injection.
- **Allergen Extracts**
- **Anti-Wrinkle Agents**
- **Cell and Gene Therapy**
- **Educational Materials**
- **Experimental** – Experimental drugs or drugs of questionable therapeutic value, or drugs labeled "Caution: limited by federal law to investigational use".
- **Hair Loss (Alopecia)** – Rogaine (Minoxidil) for the treatment of alopecia.
- **Illegal** – Drugs or medicines not legally dispensed under federal and/or state law, or drugs purchased outside the United States that are not legal inside the United States.
- **Immunizations** – Immunization agents, biological sera, blood, or blood plasma.
- **Nutritional Diet Supplement**
- **Over-the-Counter** – Drugs or medicines, such as over-the-counter or non-legend drugs, that are legally available without a doctor's prescription, except insulin and OTC drugs, devices, and supplies as specified by the Affordable Care Act.
- **Therapeutic** – Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, and other non-medical items.
- **Timely Filing** – Initial claims received by the Prescription Drug Claims Administrator later than one year after the date the drug, treatment, or service (on which the claim is based) is rendered or otherwise provided.

HOW TO FILE A PRESCRIPTION DRUG CLAIM

In-Network Pharmacies – Many pharmacies participate in the Prescription Drug Plan. When you go to an in-network pharmacy, show your identification card. It provides the pharmacy with important information about your coverage. The pharmacy will collect your copay and fill your prescription.

Out-of-Network Pharmacies – You must submit a claim directly to the Prescription Drug Plan when you purchase a prescription from an out-of-network pharmacy. The Prescription Drug Plan will only pay the maximum contracted price for each prescription, less your copay. The maximum contracted price used for reimbursement will probably be less than the amount you are charged. Reimbursement will be sent directly to you.

Mail Service Prescription Drug Program – The Mail Service Prescription Drug Program provides benefits for insulin and maintenance drugs that require a prescription by law to purchase. The maximum quantity that can be claimed is a 90-day supply, which is more than can be obtained under the regular Prescription Drug Plan. Use of the Mail Service Prescription Drug Program will

save you trips to the pharmacy and minimizes prescription copays. You can obtain information from Capital RX's website at: www.cap-rx.com

HOW TO APPEAL A DENIED PRESCRIPTION DRUG CLAIM

If a Participant or a Participant's spouse, dependent, or beneficiary (hereinafter referred to as a "Claimant") is denied any prescription drug benefit under the Prescription Drug Plan, the Claimant may request review of the claim by contacting the Prescription Drug Claims Administrator. The process for appealing a denied claim is described in Chapter 5.

CHAPTER 4

UTILIZATION MANAGEMENT

PENALTIES FOR NOT COMPLYING WITH PRE-CERTIFICATION AND CONTINUED STAY REVIEW:

a. The following services require pre-certification:

Hospital and Other Inpatient Facility Admissions

1. Inpatient Hospital *
2. Extended Care Facility / Skilled Nursing Facility *
3. Rehabilitation Facility *
4. Inpatient Hospice *
5. Birthing Center *
6. Residential Treatment Facility *

Outpatient Procedures and Services

1. Advanced Radiology – MRI, MRA, PETScan, CTScan and Nuclear Medicine *
2. Ambulatory Surgical Facility *
3. Outpatient Hospital *
4. Renal Dialysis *
5. Chemotherapy *
6. Radiation Therapy *
7. Air Ambulance *
8. Clinical Trials (Patient Costs) *
9. Durable Medical Equipment *
10. Genetic Testing *
11. Home Health Care *
12. Hospice – Outpatient Care *
13. Private Duty Nursing *
14. Intensive Outpatient Services *
15. Partial Hospitalization *

* If this service is not pre-certified, a penalty will apply, as described below.

CARE COORDINATION – OVERVIEW

The Plan incorporates a Care Coordination process administered by Quantum Health. This process includes a staff of Care Coordinators who receive notification regarding most healthcare services sought by Participants and coordinate activities and information flow between the providers.

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

Care Coordinators: 844-460-2801

To receive the highest benefits available in the Plan, Participants must follow the Care Coordination process outlined in this section. In some cases, failure to follow this process of care can result in significant benefit reductions, penalties, or even loss of benefits for specific services. The process of care generally includes:

- Designation of a coordinating physician (a Primary Care Physician, referred to as a PCP), and
- A review and coordination process, including:
 - Pre-certification of certain procedures
 - Utilization Review
 - Concurrent Review of hospitalization and courses of care
 - Case Management.

As described below, pre-certifications are generally requested by providers on behalf of their Participants.

DESIGNATED COORDINATING PHYSICIAN

To ensure the highest level of benefits and the best coordination of your care, all Participants are encouraged at enrollment to designate an in-network Primary Care Physician (PCP) to be their coordinating physician. While such designation is not mandatory, it is strongly recommended.

The Care Coordination process generally begins with the coordinating physician, a PCP who maintains a relationship with the Participant and provides general healthcare guidance, evaluation, and management. The following types of physicians can be selected by Participants as their PCP:

- Family Medicine
- General Practice
- Internal Medicine
- Pediatrician (for children)
- OB/GYN **ONLY** during a woman's pregnancy.

Participants are encouraged to begin all healthcare events or inquiries with a call or visit to a PCP, who will guide patients as appropriate. In addition to providing care coordination and submitting pre-certification requests, the PCP may also receive notices regarding healthcare services that

their designated patients receive under the Plan. This allows the PCP to provide ongoing healthcare guidance.

If you have trouble obtaining access to a PCP, the Care Coordinators may be able to assist you by providing a list of available PCPs and even contacting PCP offices on your behalf. Please contact the Care Coordinators at **844-460-2801**.

Use of In-Network Providers

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

COMPONENTS OF THE CARE COORDINATION PROCESS

Pre-Certification of Certain Procedures

To be covered at the highest level of benefits and to ensure complete care coordination, the Plan requires that certain care, services, and procedures be pre-certified **before** they are provided. Pre-certification requests are submitted to the Care Coordinators by a specialty physician, designated PCP, other PCP, or other healthcare provider. Your Plan identification card includes instructions.

Depending on the request, the Care Coordinators may contact the requesting provider to obtain additional clinical information to support the need for the pre-certification request and to ensure that the care, service, and/or procedures meet Plan criteria. If a pre-certification request does not meet Plan criteria, the Care Coordinators will contact the Participant and healthcare provider and assist in redirecting care, if appropriate.

The following services require pre-certification:

- Inpatient Hospital
- Advanced Radiology – MRI, MRA, PETScan, CTScan and Nuclear Medicine
- Ambulatory Surgical Facility
- Extended Care Facility / Skilled Nursing Facility
- Rehabilitation Facility
- Outpatient Hospital
- Renal Dialysis
- Chemotherapy
- Radiation Therapy
- Air Ambulance
- Clinical Trials (Patient Costs)
- Durable Medical Equipment
- Genetic Testing
- Home Health Care
- Inpatient Hospice
- Hospice – Outpatient Care
- Private Duty Nursing
- Birthing Center
- Residential Treatment Facility

- Intensive Outpatient Services
- Partial Hospitalization

Utilization Review

The Care Coordinators will review each pre-certification request to evaluate whether the requested care, procedure, and care setting all meet utilization criteria established by the Plan. The Plan has adopted the utilization criteria in use by the Care Coordinators.

If a pre-certification request does not meet these criteria, the request will be reviewed by one of the medical directors for Quantum Health, who will review all available information and, if needed, consult with the requesting provider. If required, the medical director will also consult with other professionals and medical experts with knowledge in the appropriate field.

He or she will then provide, through the Care Coordinators, a recommendation to the Plan Administrator whether the request should be approved, denied, or allowed as an exception. In this manner, the Plan ensures that pre-certification requests are reviewed according to nationally accepted standards of medical care, based on community healthcare resources and practices.

Concurrent Review

The Care Coordinators will regularly monitor a hospital stay, other institutional admission, or ongoing course of care for any Participant, and examine the possible use of alternate facilities or forms of care. The Care Coordinators will communicate regularly with attending physicians, the Utilization Management staff of such facilities, and the Participant and/or family to monitor the patient's progress and anticipate and initiate planning for future needs (discharge planning). Such concurrent review and authorization for Plan coverage of hospital days is conducted in accordance with the utilization criteria adopted by the Plan and Quantum Health.

Case Management

Case Management is ongoing, proactive coordination of a Participant's care in cases where the medical condition is, or is expected to become, catastrophic or chronic, or when the cost of treatment is expected to be significant. Examples of conditions that could prompt Case Management intervention include, but are not limited to, cancer, chronic obstructive pulmonary disease, multiple trauma, spinal cord injury, stroke, head injury, AIDS, multiple sclerosis, severe burns, severe psychiatric disorders, high risk pregnancy, and premature birth.

Case Management is a collaborative process designed to meet a Participant's health care needs and maximize their health potential, while effectively managing the costs of care needed to achieve this objective. The case manager will consult with the Participant, the attending physician, and other members of the Participant's treatment team to assist in facilitating and implementing proactive plans of care that provide the most appropriate health care and services in a timely, efficient, and cost-effective manner.

If the case manager, Participant, and the Plan Administrator all agree on alternative care that can reasonably be expected to achieve the desired results without sacrificing the quality of care, the Plan Administrator may alter or waive the normal provisions of this Plan in order to cover such alternative care, at the benefit level determined by the Plan Administrator.

In developing an alternative plan of treatment, the case manager will consider:

- The Participant's current medical status
- The current treatment plan
- The potential impact of the alternative plan of treatment
- The effectiveness of such care
- The short-term and long-term implications of this treatment plan.

If an alternative plan of treatment is warranted, the Care Coordinators will submit this plan to the Claims Administrator and/or stop-loss carrier for prior review and approval.

The Plan Administrator retains the right to review the Participant's medical status while the alternative plan of treatment is in process, and to discontinue the alternative plan of treatment with respect to medical services and supplies that are not covered under the Plan, due to any of the following:

- The attending physician does not provide medical records or information necessary to determine the effectiveness of the alternative plan of treatment
- The goal of the alternative care of treatment has been met
- The alternative plan of care is not achieving the desired results or is no longer beneficial to the Participant.

Chronic Condition Management

Chronic Condition Management (also referred to as Disease Management) is specialized support and coordination for Participants with lifelong, chronic conditions such as diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, and asthma. Chronic Condition Management is a collaborative process that is designed to help Participants self-manage such conditions, based on care pathways with respect to such disease states, including, but not limited to: assisting Participants to understand the care pathway and set goals, facilitating dialogue with physicians if there are complications or conflicts with the Participant's care, evaluating ways to eliminate barriers to successful self-management, and generally maximizing the Participant's health.

Participants who are identified from claims, biometrics, or other sources will be assessed for level of risk for each disease state and may be contacted proactively by a Chronic Condition Case Manager (also referred to as Disease Manager). Participants whose information indicates they are high risk will be contacted by a Chronic Condition Case Manager for an assessment and ongoing assistance and will be asked to update their care pathway information biannually. Participants who are low or moderate risk may request assistance of a Chronic Condition Case Manager and will also be asked to update their care pathway information on a biannual basis.

Participation in Chronic Condition Management is voluntary, but Participants may receive various prescription medications and supplies at a reduced cost or may be entitled to benefits that non-Participants do not receive.

GENERAL PROVISIONS

Authorized Representative

The Participant is ultimately responsible for ensuring that all pre-certifications are approved and in place prior to the time of service in order to receive the highest level of benefits. However, in most cases, the actual pre-certification process will be executed by the Participant's physician(s)

or other providers. By participating in this Plan, the Participant authorizes the Plan and its designated service providers (including Quantum Health, the third-party administrator, and others) to accept healthcare providers that make pre-certification submissions, or who otherwise have knowledge of the Participant's medical condition, as their authorized representative in matters of Care Coordination. Communications with and notifications to such healthcare providers shall be considered notification to the Participant.

Time of Pre-certification or Notice

Pre-certifications of elective (non-emergency) admissions or Notice of non-elective (emergency) admissions, as required, should be made to the Care Coordinators within the following timeframes:

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

Emergency Admissions and Procedures

Any hospital admission or outpatient procedure that has not been previously scheduled and cannot be delayed without harming the patient's health is considered an emergency for purposes of the utilization review notification.

Maternity Admissions

A notice regarding admissions for childbirth should be submitted to the Care Coordinators in advance, preferably 30 days prior to expected delivery. The Plan and the Care Coordination process complies with all state and federal regulations regarding utilization review for maternity admissions.

Care Coordination Is Not a Guarantee of Payment of Benefits

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

Result of Not Following the Coordinated Process of Care

Failure to comply with the Care Coordination process of care may result in reduction in or loss of benefits.

Appeal of Care Coordination Determinations

Participants have certain appeal rights regarding adverse determinations in the Care Coordination process, including reduction of benefits and penalties. The appeal process is detailed in the Claims and Appeals Process section.

CHAPTER 5

GENERAL INFORMATION

COORDINATION OF BENEFITS

This Plan contains a non-profit provision coordinating it with other similar plans under which an individual may be covered so that the total benefits available during the Plan Year will not exceed the benefits of this Plan that would have been provided in the absence of Coordination of Benefits.

If, in coordinating the benefits of this Plan with those of another plan, the rules set forth in the following Order of Benefit Determination paragraph would require this Plan to be the primary payer and the other plan, according to its rules, is the secondary payer, then the benefits of that other plan will be ignored for the purpose of determining the benefits of this Plan.

If, in coordinating the benefits of this Plan with those of another plan, the rules set forth in the following Order of Benefit Determination paragraph would require this Plan to be the secondary payer, and the other plan the primary payer, then benefits will be paid by this Plan to the extent of the difference between the dollar amount the primary plan will pay and the dollar amount of allowable expenses.

An "allowable expense" is a health care service or expense including deductibles, coinsurance or copays that is covered in full or in part by any of the plans involved.

"Plans" means these types of medical benefits:

- a. Group insurance and group subscribed contracts;
- b. Uninsured arrangements of group or group-type coverage;
- c. Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans;
- d. Group-type contracts (obtained and maintained only because of membership in a particular organization or group);
- e. Group, group-type or individual automobile "no fault" and traditional automobile "fault" type policies;
- f. Medicare or other government benefits;
- g. Group or group-type hospital indemnity benefits in excess of \$200 per day; or
- h. Medical care portions of group long-term care contracts (such as skilled nursing care).

Order of Benefit Determination: When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the allowable expenses.

A plan without a coordination provision similar to this Plan is always the primary plan. If all plans have such a provision:

- a. The plan covering the patient directly, rather than as an Employee's dependent, is primary;
- b. If a child is covered under both parent's plans, the plan of the parent whose birthday (day and month only, without regard to the year of birth) comes earlier in the year is primary; however when the parents are separated or divorced, their plans pay in this order:
 - 1) If court decree has established financial responsibility for the child's health care expenses, the plan of the parent with this responsibility;

- 2) The plan of the parent with custody of the child;
 - 3) The plan of the stepparent married to the parent with custody of the child; and
 - 4) The plan of the parent not having custody of the child;
- c. Active/Inactive Employee: The plan covering a person as an Employee who is neither laid off nor retired (or as that person's dependent) pays benefits first. The plan covering that person as a laid off or retired Employee (or as that person's dependent) pays benefits second. If both plans do not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored;
 - d. If none of the above rules determine the order of benefits, the plan covering the patient longest is primary. The plan covering that person for the shorter time pays second; or
 - e. If none of the previously discussed rules apply, then the plans are to share the allowable expenses equally.

This Plan will always be primary for an expense incurred by a disabled Participant age 65 or under, other than a retired Employee, for which Medicare benefits are available. This does not apply to charges incurred for End Stage Renal Disease.

With respect to a Participant's automobile insurance coverage, no fault and otherwise, where permitted by law, that coverage shall be primary to the coverage afforded by this Plan.

The Plan covering the individual as an Employee, retiree, or as a Dependent of an Employee will be primary, and the plan providing continuation coverage (COBRA) will be secondary. There are different rules for Medicare and COBRA. See that section below.

When the above rules reduce the total amount of benefits otherwise payable under this Plan, each benefit charge that would be payable shall be reduced proportionately.

EFFECT OF MEDICARE

Active Employees and Spouses Age 65 and Over - An Employee in Active Service or a covered Dependent spouse who is eligible for Medicare because he or she reaches age 65, has the following options:

- a. Continue primary coverage under this Plan (under this option, benefits provided under this Plan will continue to be paid without regard to Medicare while the individual remains eligible for coverage under the Plan); or
- b. Drop coverage under the Plan and enroll in or maintain coverage under Medicare.

No action is required, solely because of Medicare eligibility or enrollment, for the individual to maintain coverage under this Plan. If the Medicare-eligible individual does not choose to drop coverage under the Plan, the Plan will continue to be primary, regardless of whether he or she enrolls in Medicare.

Retirees and Spouses Age 65 and Over - Medicare is primary and the Plan will be secondary for the Participant if the individual is age 65 and over and retired. Medicare is primary and the Plan will be secondary for the dependent spouse if both the Participant and their covered dependent spouse are age 65 and over and retired.

If the retiree (or spouse) is eligible for Medicare and does not choose to enroll, this Plan will pay as if Medicare were primary.

Disability Due to End Stage Renal Disease (ESRD) - If a Participant becomes eligible for benefits under Medicare as a result of disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payer for the first 30 months of Medicare eligibility. After the initial 30 months of Medicare eligibility, Medicare will be the primary payer.

Disability (other than End Stage Renal Disease) and Medicare - Medicare is the primary payer for individuals who are entitled to Medicare due to a determination of disability by the Social Security Administration (other than End Stage Renal Disease) who are under age 65 and who have coverage under a Plan covering 100 or more Employees. However, if the coverage under the group health Plan is by virtue of the “current employment status” of the individual or a family member then Medicare is the secondary payer.

COBRA and MEDICARE

Medicare due to ESRD at the time of COBRA election- Medicare is the secondary payer for individuals entitled to Medicare due to ESRD who have COBRA coverage under the Plan for the first 30 months of Medicare entitlement. After 30 months, if the COBRA coverage is still in effect, Medicare becomes the primary payer.

Medicare due to Age at the time of COBRA election- Medicare is the primary payer and the COBRA Plan the secondary payer. If the retiree (or spouse) is eligible for Medicare and does not choose to enroll, this Plan will pay as if Medicare were primary.

Medicare due to Disability at the time of COBRA election - Medicare is the primary payer for individuals entitled to Medicare due to disability and under age 65 who have COBRA coverage under a Plan covering 100 or more Employees. However, if the coverage under the group health plan is by virtue of the “current employment status” of the individual or a family member then Medicare is the secondary payer.

For purposes of the above rules, COBRA coverage is not by virtue of “current employment status” if it is based on a qualifying event that was the Employee’s termination of employment, or reduction in hours of employment or the death of a covered Employee.

CLAIM PROVISIONS

PROOF OF LOSS – A completed claim form, corresponding itemized bills, and other information necessary to process a claim represent proof of loss incurred by the Participant. Initial claims must be received by the Claims Administrator or the Prescription Drug Claims Administrator no later than one year after the date the treatment or service (on which the claim is based) is rendered or otherwise provided.

The Plan reserves the right at its discretion to accept or to require verification of any alleged fact or assertion pertaining to any claim.

In the event of Plan termination, all claims incurred by a Participant must be received by the Claims Administrator or the Prescription Drug Claims Administrator within one year after the date of termination of the Plan.

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

EXAMINATION - The Plan, at its own expense, shall have the right and opportunity to have the Participant examined whose injury or sickness is the basis of a claim when and as often as it may reasonably require during the processing of the claim. The Claims Administrator shall also have the right and opportunity to have an autopsy performed where it is not forbidden by law.

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

- a. The provider of services; or
- b. A surviving relative (Spouse, parent or child).

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

GENDER AND NUMBER - The masculine gender shall be deemed to include the feminine and the singular shall include the plural unless otherwise clearly required by the context.

RECOVERY OF PAYMENTS - Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Allowed Benefit. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Participant or dependent on whose behalf such payment was made.

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

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

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

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

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

- 1) In error;
- 2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- 3) Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
- 4) With respect to an ineligible person;
- 5) In anticipation of obtaining a recovery if a Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
- 6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits

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

The deduction may be made against any claim for benefits under this Plan by a Participant or by any of his covered Dependents if such payment is made with respect to the Participant or any person covered or asserting coverage as a Dependent of the Participant.

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

CLAIM FILING INSTRUCTIONS

In-Network Providers Within the CFA Service Area

Simply present your CFA Identification Card at the time you receive services. The provider will file a claim with CFA and will be directly reimbursed for the services you receive.

Out-of-Network Providers Within the CFA Service Area

Reimbursement of health care expenses for services rendered by Out-of-Network Providers within the CFA service area is handled by CFA. Claims may be filed by a facility, a provider's office, or the Participant. Payment will be made by CFA to either the provider or the Participant.

You do not need a claim form to file your claims. Mail your itemized bill from the provider and include the following information:

- Employee name
- Employee's identification number
- Patient name
- Employer name or group number
- Provider's Tax ID Number (TIN)
- Procedure code
- Diagnosis code
- Date of service
- Charge for each service

Balance due bills are not acceptable. The bill for processing claims must include all the information described above. Send all claims, appeals, and written inquiries to:

Mail Administrator
P.O. Box 981608
El Paso, Texas 79998

The toll-free telephone number is: 877-889-2478

Providers Outside the CFA Service Area

Claims for services rendered outside the CFA service area will be handled by the Host Blue. Refer to the *Inter-Plan Arrangements* section for additional information.

NOTE ON HOSPITAL CHARGES

Claims for inpatient admissions are usually filed by the hospital. Most hospitals will verify that your health coverage is in effect and will handle the paperwork on your behalf. If you do receive a bill for inpatient services, do not pay it until you are certain that your claim has been settled. In some instances, the Participant is responsible for balances. When you are unsure, contact the hospital or CFA for guidance.

Remember – Pre-certification or Notice is required for certain services. Failure to call the Utilization Management Vendor may reduce your benefits. Refer to Chapter 4 for additional information.

Call Quantum Health at 844-460-2801

CLAIMS AND APPEALS PROCESS

Claims for benefits under the Plan must be filed in the manner and within the time limits stated under “Proof of Loss” above. If a Participant or a Participant’s spouse, dependent or beneficiary (hereinafter referred to as a “Claimant”) is denied any Benefit under this Plan, the Claimant may request review of the claims with the Plan. The claims procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Plan shall review the claim itself or appoint an individual or an entity to review the claim.

A Claimant is not required to follow more than the claims and appeals process described below prior to bringing a civil action under ERISA or under state law, as applicable. Nothing herein shall be construed to mean or imply that a non-ERISA group health plan has deemed itself subject to ERISA.

If the Plan fails to adhere to the internal claims and appeals process required by this chapter, a Claimant shall be deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under Section V of this chapter and is entitled to pursue any available remedies under ERISA section 502(a) or under state law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

The internal claims and appeals process will not be deemed exhausted based on minor violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan.

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the Claimant’s request for immediate review on the basis that the Plan met the standards for the exception in the preceding paragraph, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant’s receipt of such notice.

I. INITIAL BENEFIT DETERMINATION

Urgent Care Claims

In the case of an Urgent Care Claim, the Plan shall notify the Claimant of the Plan’s benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

Concurrent Care Claims

If the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments shall constitute an Adverse Benefit Determination. In such a case, the Plan shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain an appeal determination of that Adverse Benefit Determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Plan shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Continued coverage for concurrent care shall be provided pending the outcome of an appeal.

Pre-Service Claims

In the case of a pre-service claim, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan.

This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim is considered a pre-service claim if the claim requires approval, in whole or in part, in advance of obtaining the health care in question.

In the case of a failure by a Claimant to follow the Plan's procedures for filing a pre-service claim, the Claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the Claimant as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of a failure to file an Urgent Care Claim) following the failure. Notification may be oral, unless written notification is requested by the Claimant. The above shall apply only in the case of a failure that:

- a. Is a communication by a Claimant that is received by the person or organizational unit designated by the Plan that handles benefit matters; and
- b. Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

Post-Service Claims

In the case of a post-service claim, the Plan shall notify the Claimant of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim.

This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim, as defined above.

Other Claims

In the case of claims that do not fall under the categories listed above, the Plan shall notify the Claimant of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, the Plan shall furnish written notice of the extension to the Claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render a decision.

Calculation of Time Periods

For purposes of the time periods specified in this Section I, the period of time within which a benefit determination shall be made begins at the time a claim is filed in accordance with Plan procedures, without regard to whether all the information necessary to make a benefit determination accompanies the claim. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the claim, the period for making the benefit determination shall be tolled from the date the notification of the extension is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Notification of Adverse Benefit Determination

The Plan shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Claimant:

- a. The specific reason(s) for the adverse determination;

- b. A reference to the specific Plan provisions on which the determination is based;
- c. A description of any additional information or material necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
- d. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502(a) or under state law, as applicable, following an appeal of an Adverse Benefit Determination;
- e. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
- f. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- g. In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, a description of the expedited review process applicable to such claims.

In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described above may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this section is furnished to the Claimant not later than three (3) days after the oral notification.

II. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

The Plan provides two levels of internal appeals. A Claimant has the right to file an appeal to the Plan within 180 days from the date of the initial Adverse Benefit Determination notice and within 30 days of the date of a second Adverse Benefit Determination notice. The Claimant's appeal request must include the patient's name, identification number, and any additional documentation to be reviewed.

- a. A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- b. A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. For purposes of this chapter, such information will be considered "relevant" if it:
 - (i) Was relied on in making the benefit determination;

- (ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination;
 - (iii) Demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or
 - (iv) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination;
- c. The Plan shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
- d. The Plan shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically:
 - (i) The Plan shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date; and
 - (ii) Before the Plan issues a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date;
- e. The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits;
- f. The Plan shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
- g. In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental or Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who was neither consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual; and

- h. The Plan shall identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

In the case of an Urgent Care Claim, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's appeal determination, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

III. DEADLINE FOR REVIEW DECISIONS

Urgent Care Claims

This Plan has two levels of internal appeals. In the case of Urgent Care Claims, the Plan shall notify the Claimant of the Plan's appeal determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination by the Plan.

Pre-Service Claims

This Plan has two levels of internal appeals. In the case of a pre-service claim, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such two appeals, within a reasonable time appropriate to the medical circumstances but not later than 15 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

Post-Service Claims

This Plan has two levels of internal appeals. In the case of a post-service claim, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such two appeals, within a reasonable period but not later than 30 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

Other Claims

This Plan has two levels of internal appeals. In the case of claims that do not fall under the categories listed above, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such two appeals, within a reasonable period of time, but not later than 60 days after receipt of the Claimant's request for review of the Adverse Benefit Determination, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, the Plan shall furnish written notice of the extension to the Claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render an appeal determination.

Calculation of Time Periods

For purposes of the time periods specified in this Section III, the period of time within which an appeal determination shall be made begins at the time an appeal is filed in accordance with the Plan procedures, without regard to whether all the information necessary to make an appeal determination accompanies the filing. If a period of time is extended due to a Claimant's failure

to submit all information necessary to decide the appeal, the period for making the appeal determination shall be tolled from the date the notification requesting the additional information is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Notice of Appeal Determinations

The Plan shall provide the Claimant with written or electronic notification of its appeal determination. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Claimant:

- a. The specific reason(s) for the adverse determination;
- b. A reference to the specific Plan provisions on which the benefit determination is based;
- c. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;
- d. A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under ERISA section 502(a) or under state law, as applicable;
- e. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
- f. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- g. A statement that the Claimant may have other voluntary alternative dispute resolution options, such as mediation.

IV. GENERAL NOTICE REQUIREMENTS

When the Plan issues an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination, the notification shall meet the following requirements:

- a. The Plan shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;
- b. The Plan shall provide to a Claimant, as soon as practicable, upon request, the diagnosis and treatment codes and their corresponding meanings, associated with any Adverse

Benefit Determination or Final Internal Adverse Benefit Determination. The Plan shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or an external review;

- c. The Plan shall ensure that the reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination include the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision;
- d. The Plan shall provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
- e. The Plan shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHSA section 2793 to assist individuals with internal claims and appeals and external review processes.

V. EXTERNAL REVIEW PROCESS

Request for External Review

The Plan shall allow a Claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination). If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

The external review process applies only to an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan that involves:

- a. Medical judgment, which includes, but is not limited to, determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is Experimental or Investigational, as determined by the external reviewer;
- b. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act; and
- c. A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time.

Preliminary review

Within five (5) business days after receiving a Claimant's external review request, the Plan shall complete a preliminary review of the request to determine whether:

- a. The Claimant is (or was) covered under the Plan when the health care item or service was requested or, in the case of a retrospective review, whether the Claimant was covered under the Plan when the health care item or service was provided;

- b. The Adverse Benefit Determination does not relate to the Claimant's failure to meet the Plan's eligibility requirements;
- c. The Claimant has exhausted the Plan's internal claims and appeals process, unless the Claimant is not required to do so, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim; and
- d. The Claimant has provided all the information and forms required to process the external review.

Within one (1) business day after completion of the preliminary review, the Plan shall issue a written notice to the Claimant. If the request is complete but not eligible for external review, the notice shall include the reasons for its ineligibility, as well as contact information for the Employee Benefits Security Administration (866-444-EBSA (3272)). If the request is incomplete, the notice shall describe the information or materials needed to complete the request, which must be received by the Plan within the four-month filing period or within 48 hours after receipt of the notice, whichever is later.

Referral to Independent Review Organization

The Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the Plan shall take action against bias and to ensure independence. Accordingly, the Plan shall contract with at least three IROs for assignments under the Plan and incorporate an independent unbiased method for IRO selection. The IRO shall not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The agreement between the Plan and the assigned IRO shall include the following:

- a. The IRO shall utilize legal experts where appropriate to make coverage determinations under the Plan;
- b. The IRO shall provide the Claimant with written notice of the request's eligibility and acceptance for external review. The notice must inform Claimants that they may submit additional information in writing to the IRO within 10 business days following receipt of the notice and that the IRO must consider such additional information in its external review. The IRO may also accept and consider additional information that is submitted after 10 business days, but it is not required to do so;
- c. Within five (5) business days after the date the IRO is assigned, the Plan shall provide to the IRO the documents and any information considered in making the Adverse Benefit Determination. The Plan's failure to timely provide such documents and information shall not delay the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and reverse the Adverse Benefit Determination. If the IRO does so, it shall notify the Claimant and the Plan within one (1) business day after making the decision;
- d. Upon receipt of any information submitted by the Claimant, the IRO shall forward the information to the Plan within one (1) business day. The Plan may then reconsider its Adverse Benefit Determination, but such reconsideration shall not delay the external

- review. If the Plan decides, on reconsideration, to reverse its Adverse Benefit Determination and provide coverage or payment, then the external review can be terminated. The Plan must provide written notice to the Claimant and IRO within one (1) business day after making this decision. On receiving the Plan's notice, the IRO must terminate its external review;
- e. The IRO shall review all of the information and documents timely received. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process;
 - f. In addition to documents and information provided by the Claimant, the IRO shall consider the following items in reaching a decision (to the extent the information or documents are available and the IRO considers them appropriate):
 - (i) The Claimant's medical records;
 - (ii) The attending health care professional's recommendation;
 - (iii) Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the Claimant's treating provider;
 - (iv) The terms of the Claimant's Plan, to ensure that the IRO's decision is not inconsistent with the Plan's terms, unless the terms are contrary to applicable law;
 - (v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - (vi) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or applicable law; and
 - (vii) The opinion of the IRO's clinical reviewer(s);
 - g. Within 45 days after receiving the external review request, the IRO shall provide written notice of the final external review decision to both the Claimant and the Plan. The IRO's notice shall contain:
 - (i) A general description of the reason for the external review request, including information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial;
 - (ii) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - (iii) References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;
 - (iv) A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards that the IRO relied on;

- (v) A statement that the IRO's determination is binding on the Plan and the Claimant, unless other remedies are available under state or federal law;
 - (vi) A statement that judicial review may be available to the Claimant; and
 - (vii) Current contact information and phone number for any applicable office of health insurance consumer assistance or ombudsman established under PHSA section 2793;
- h. After a final external review decision, the IRO shall maintain records of all claims and notices associated with the external review process for six years. The IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws; and
- i. An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law. The Plan shall provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. The requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

Request for Expedited External Review

The Plan shall permit a Claimant to request an expedited external review when the Claimant receives:

- a. An Adverse Benefit Determination involving a Claimant's medical condition where the timeframe for completing an expedited *internal* appeal would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, and the Claimant has filed an expedited internal appeal request; or
- b. A Final Internal Adverse Benefit Determination involving (1) a Claimant's medical condition where the timeframe for completing a standard *external* review would seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or (2) an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services but has not been discharged from a facility.

Immediately upon receiving the expedited external review request, the Plan shall complete a preliminary review to assess whether the request meets the reviewability requirements applicable under the standard external review process set forth above. The Plan shall immediately send the Claimant a notice regarding the Plan's reviewability assessment; this notice must meet the requirements applicable under the standard external review process set forth above.

Following a preliminary review determination that a request is eligible for external review, the Plan shall assign an IRO based on the standard external review process set forth above. The Plan shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the IRO. The

documents and information can be provided electronically, by telephone or facsimile, or any other expeditious method available.

The IRO shall consider the documents and information according to the procedures for standard external review set forth above, to the extent the documents or information are available and the IRO considers them appropriate. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The agreement between the Plan and the IRO shall require the IRO to provide notice of its final external review decision; this notice must meet the requirements applicable under the standard external review process set forth above. The notice must be provided as expeditiously as the Claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the expedited external review request. If the notice is not in writing, the IRO shall provide written confirmation of the decision to the Claimant and the Plan within 48 hours after the date it provides the non-written notice.

INTER-PLAN ARRANGEMENTS

Out-of-Area Services Overview

CareFirst Administrators (CFA) has 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 Participants access health care services outside the geographic area CFA serves, 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 CFA serves, Participants obtain care from health care 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, Participants may obtain care from health care providers in the Host Blue geographic area that do not have a contractual agreement (“Non-Participating Providers”) with the Host Blue. CFA remains responsible for fulfilling its contractual obligations to you. CFA’s payment practices in both instances are described below.

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 CFA to provide the specific service or services, are not processed through Inter-Plan Arrangements.

BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this arrangement, when Participants access covered health care services within the geographic area served by a Host Blue/outside the geographic area CFA serves, the Host Blue shall be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim – In General

Participant Liability Calculation

Unless subject to a fixed dollar copay, the calculation of the Participant liability on claims for covered health care services shall be based on the lower of the Participating Provider’s billed charges for covered services or the negotiated price made available to CFA by the Host Blue.

Sponsor Liability Calculation

The calculation of Sponsor liability on claims for covered health care services processed through the BlueCard Program shall be based on the negotiated price made available to CFA 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 Provider(s) for specific health care services. In cases where the negotiated price exceeds the billed charge, the Sponsor may be liable for the excess amount even when the Participant’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.

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 CFA by the Host Blue may be represented by one of the following:

- a. 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.
- b. 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.
- c. An average price: An average price is a percentage of billed charges for covered services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its health care 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 shall 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 the Sponsor 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 Participant and the Sponsor is a final price; no future price adjustment shall 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 the Sponsor shall be adjusted in a following year, as necessary, to account for over- or underestimation of the past years' prices. The Host Blue shall 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 the Sponsor. If the Sponsor terminates, you shall not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid claims amounts and shall be liquidated or drawn down 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.

BlueCard Program Fees and Compensation

The Sponsor understands and agrees to reimburse CFA for certain fees and compensation which CFA 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 the Sponsor are stated in CFA's contractual agreement with the Sponsor. BlueCard Program fees and compensation may be revised from time to time as described in the section titled "Modifications or Changes to Inter-Plan Arrangement Fees or Compensation" below.

Special Cases: Value-Based Programs

Value-Based Programs Overview

Sponsor's Participants may access covered 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

Value-Based Programs Administration

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 CFA, which CFA shall pass directly on to the Sponsor 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:

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

- a. **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. CFA shall pass these Host Blue charges directly through to the Sponsor as a separately identified amount on the group billings.

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 shall be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard Program

Claims 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 shall take one of the following actions:

- a. Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
- b. 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 shall not receive compensation resulting from how estimated, average, or PMPM price methods, described above, are calculated. If the Sponsor terminates, you shall 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 stated in CFA's contractual agreement with the Sponsor.

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated or drawn down 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: Participants shall 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 CFA for Care Coordinator Fees for provider services which CFA shall pass on to the Sponsor as follows:

- a. PMPM billings; or
- b. 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 the contractual agreement between CFA and the Sponsor, CFA and the Sponsor shall not impose Participant cost-sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

If CFA has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Sponsor's Participants, CFA shall follow the same procedures for Value-Based

Programs administration and Care Coordinator Fees as noted in the BlueCard Program section above.

For Negotiated Arrangements, when Control/Home Licensees have negotiated with accounts to waive Participant cost-sharing for Care Coordinator Fees, the following provision shall apply: As part of the contractual agreement between CFA and the Sponsor, CFA and the Sponsor may agree to waive Participant cost-sharing for Care Coordinator Fees.

Return of Overpayments

Recoveries from a Host Blue or its Participating and Non-Participating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits, health care provider/hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recovery amounts determined in the ways noted above shall be applied so that corrections shall 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 CFA, they shall be credited to the Sponsor account. In some cases, the Host Blue shall engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to the Sponsor as a percentage of the recovery.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, CFA shall request the Host Blue to provide full refunds from Participating Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original claim. For Care Coordinator Fees associated with Value-Based Programs, CFA shall request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or health care provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, or (c) would jeopardize the Host Blue's relationship with its Participating Providers, notwithstanding to the contrary any other provision of this agreement.

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, CFA shall disclose any such surcharge, tax, or other fee to the Sponsor, which shall be Sponsor's liability as soon as practicable.

Non-Participating Providers Outside the CFA Service Area

Participant Liability Calculation

In General

When covered health care services are provided outside of CFA's service area by Non-Participating Providers, the amount(s) a Participant pays for such services shall be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state/federal law. In these situations, the Participant may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment CFA shall make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services shall be governed by applicable federal and state law.

Exceptions

In some exception cases, at Sponsor direction, CFA may pay claims from Non-Participating Providers outside of CFA's service area based on the provider's billed charge. This may occur in situations where a Participant did not have reasonable access to a Participating Provider, as determined by CFA in CFA's sole and absolute discretion or by applicable state/federal law. In other exception cases, at Sponsor direction, CFA may pay such claims based on the payment CFA would make if CFA were paying a Non-Participating Provider inside of CFA's service area, as described elsewhere in this document. This may occur where the Host Blue's corresponding payment would be more than CFA's in-service area Non-Participating Provider payment. CFA may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Participant may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment CFA shall make for the covered services as set forth in this paragraph.

Fees and Compensation

The Sponsor understands and agrees to reimburse CFA for certain fees and compensation which CFA is 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 the Sponsor are set forth in CFA's contractual agreement with the Sponsor. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in the section titled "Modifications or Changes to Inter-Plan Arrangement Fees or Compensation" below.

Blue Cross Blue Shield Global Core

General Information

If Participants 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 when accessing covered health care services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists Participants with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when Participants receive care from providers outside the BlueCard service area, the Participants will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if Participants contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals shall not require Participants to pay for covered inpatient services, except for their cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital shall submit Participant claims to the Blue Cross Blue Shield Global Core Service Center to initiate claims processing. However, if the Participant paid in full at the time of service, the Participant must submit a claim to obtain reimbursement for covered health care services.

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When Participants pay for covered health care services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Participants should complete a Blue Cross Blue Shield Global Core 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 CFA, the Blue Cross Blue Shield Global Core Service Center, or online at www.bcbsglobalcore.com. If Participants need assistance with their claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

Blue Cross Blue Shield Global Core Program-Related Fees

The Sponsor understands and agrees to reimburse CFA for certain fees and compensation which CFA is 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 the Sponsor under the Blue Cross Blue Shield Global Core Program are set forth in CFA's contractual agreement with the Sponsor. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in the section titled "Modifications or Changes to Inter-Plan Arrangement Fees or Compensation" below.

Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

Modifications or changes to Inter-Plan Arrangement fees are generally made effective January 1 of the Calendar Year, but they may occur at any time during the year. In the case of any such modifications or changes, CFA shall provide the Sponsor with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation, describing the change and the effective date thereof and Sponsor's right to terminate this Agreement without penalty, by giving written notice of termination before the effective date of the change. If the Sponsor fails to respond to the notice and does not terminate this Agreement during the notice period, the Sponsor shall be deemed to have approved the proposed changes, and CFA shall then allow such modifications to become part of this Agreement.

FEDERAL LAWS

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 - The Newborns' and Mothers' Health Protection Act of 1996 establishes restrictions on the extent to which group health plans and health insurance issuers may limit the length of stay for mothers and newborn children following delivery.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). *However, if your or your newborn's medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact the Utilization Management Vendor for pre-certification of the additional days.*

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 - If you are receiving covered benefits for a mastectomy, you should know that your Plan complies with the Women's Health and Cancer Rights Act of 1998. The Act provides for:

- 1) Reconstruction of the breast(s) on which a covered mastectomy has been performed;
- 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- 3) Prosthesis and physical complications related to all stages of covered mastectomy, including lymphedema.

All applicable benefit provisions still apply, including existing deductibles, copays, and/or coinsurance.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) – If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your Employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If

you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored Plan.

If you or your Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your Employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility:

ALABAMA – Medicaid

Website: <http://myalhipp.com/>

Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: <http://myakhipp.com/>

Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program

<http://dhcs.ca.gov/hipp>

Phone: 916-445-8322

Fax: 916-440-5676

Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>

Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711

CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>

CHP+ Customer Service: 1-800-359-1991/ State Relay 711

Health Insurance Buy-In Program (HIBI):

<https://www.mycohibi.com/>

HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html>

Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website:

<https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 678-564-1162, Press 1

GA CHIPRA Website:

<https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>

Phone: (678) 564-1162, Press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: <http://www.in.gov/fssa/hip/>

Phone: 1-877-438-4479

All other Medicaid

Website: <https://www.in.gov/medicaid/>

Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:

<https://dhs.iowa.gov/ime/members>

Medicaid Phone: 1-800-338-8366

Hawki Website:

<http://dhs.iowa.gov/Hawki>

Hawki Phone: 1-800-257-8563

HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:

<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 1-855-459-6328

Email: KIHIPPPROGRAM@ky.gov

KCHIP Website: <https://kynect.ky.gov>

Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-977-6740

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840

TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website:

<https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfp.nv.gov>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website:

<https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

Phone: 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Medicaid Phone: 609-631-2392

CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>

Phone: 1-800-692-7462

CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](#)

CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>

Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>

Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: [Health Insurance Premium Payment \(HIPP\)](#)

[Program | Texas Health and Human Services](#)

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>

CHIP Website: <http://health.utah.gov/chip>

Phone: 1-877-543-7669

VERMONT – Medicaid

Website: [Health Insurance Premium Payment \(HIPP\) Program | Department of Vermont Health Access](#)

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>

<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>

Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: <https://dhhr.wv.gov/bms/>

<http://mywvhipp.com/>

Medicaid Phone: 304-558-1700

CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>

Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

or

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI) - Effective April 14, 2004, the Plan will not use or disclose PHI except as permitted by this section or as otherwise permitted or required by law, including but not limited to the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (the “HIPAA Privacy Standards”), as they may be amended from time to time. Nothing in this section shall be construed to prohibit the Plan Sponsor’s receipt of “summary health information,” as described in the HIPAA Privacy Standards, for certain Plan Sponsor-related purposes, including obtaining premium bids for health insurance, making Plan design and funding decisions, and modifying, amending or terminating the Plan.

PLAN SPONSOR’S OBLIGATIONS REGARDING PROTECTED HEALTH INFORMATION (PHI) - Effective April 14, 2004, the Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor to the Plan that the Plan has been amended to provide for the Plan Sponsor’s receipt of PHI and that the Plan Sponsor agrees to comply with the following provisions:

- 1) The Plan Sponsor may use or disclose PHI for Plan enrollment purposes, including information as to whether an individual is enrolled in the Plan.
- 2) The Plan Sponsor may use or disclose PHI for Plan administration functions, including for payment or health care operations purposes (as those terms are defined by the HIPAA

Privacy Standards), and including quality assurance, Claims processing, auditing and monitoring of the Plan.

- 3) The Plan Sponsor may not use or further disclose PHI other than as permitted or required by the Plan documents or by law.
- 4) The Plan Sponsor must ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with regard to the PHI.
- 5) The Plan Sponsor may not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or other Employee Benefit Plan of the Plan Sponsor.
- 6) The Plan Sponsor must report to the Plan any use or disclosure of the PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for under the terms of the Plan.
- 7) The Plan Sponsor must make PHI available for access in accordance with the HIPAA Privacy Standards regarding an individual's right to access his/her PHI.
- 8) The Plan Sponsor must make PHI available for amendment and, if required by the HIPAA Privacy Standards, incorporate any amendment made to PHI in accordance with the HIPAA Privacy Standards regarding an individual's right to have his PHI amended.
- 9) The Plan Sponsor must make available information necessary to provide an accounting to an individual in accordance with the HIPAA Privacy Standards regarding an individual's right to receive an accounting of disclosures of his/her PHI.
- 10) The Plan Sponsor must make internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Standards.
- 11) The Plan Sponsor must, if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor must limit further uses and disclosures to those purposes that make the return or destruction not feasible.
- 12) The Plan Sponsor must ensure adequate separation between the Plan and the Plan Sponsor by restricting access to and use of the PHI to only those Employees of the Plan Sponsor with responsibilities related to the administrative functions the Plan Sponsor performs for the Plan, as identified by job title or classification below:

Vice President of Human Resources

Sr Director of Benefits and Worklife

Service Center Representatives, Consultants, and Supervisor

Director and Manager of Benefits Compliance and Ops

Director of Benefits Strategy & Service Benefits

- 13) The Plan Sponsor must ensure adequate separation between the Plan and the Plan Sponsor by maintaining a procedure for resolving any issues of noncompliance with provisions of the Plan document by persons described in paragraph 12 above through training, sanctions and other disciplinary action, as necessary.
- 14) The Plan Sponsor shall not directly or indirectly receive remuneration in exchange for any PHI without valid authorization that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving PHI of the individual making authorization, except as otherwise allowed under the American Recovery and Reinvestment Act.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI) - Effective April 20, 2006, the Plan will not use or disclose ePHI except as permitted by this section or as otherwise permitted or required by law, including but not limited to the requirements of 45 CFR Sections 164.314(b)(1) and (2) and its implementing regulations, 45 CFR parts 160, 162, and 164 of the Security Standards of the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Security Standards"), as they may be amended from time to time. Nothing in this section shall be construed to prohibit the Plan Sponsor's receipt of "summary health information," as described in the HIPAA Security Standards, for certain Plan Sponsor-related purposes, including obtaining premium bids for health insurance, making Plan design and funding decisions, and modifying, amending or terminating the Plan.

PLAN SPONSOR'S OBLIGATIONS REGARDING ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI) - Effective April 20, 2006, the Plan will disclose ePHI to the Plan Sponsor only upon receipt of an amendment to the Plan that the Plan has been amended to provide for the Plan Sponsor's receipt of ePHI and that the Plan Sponsor agrees to comply with the following provisions:

- 1) The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.
- 2) The Plan Sponsor shall ensure the adequate separation that is required by 45 CFR Section 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures.
- 3) The Plan Sponsor shall ensure any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect such information.
- 4) The Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - a. The Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's ePHI.
 - b. The Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis semi-annually, or more frequently upon the Plan's request.

BREACH AND SECURITY INCIDENTS - Effective September 23, 2009, the Health Information Technology for Economic and Clinical Health Act (HITECH) of the American Recovery and Reinvestment Act of 2009 (ARRA) imposes notification in the event of a Breach of unsecured Protected Health Information (PHI).

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

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

- 2) Identify Protected Health Information that was subject to the non-permitted use or disclosure or Breach (such as whether full name, Social Security number, date of birth, home address, account number or other information was involved) on an individual-by-individual basis;
- 3) Identify who made the non-permitted use or disclosure and who received the non-permitted disclosure;
- 4) Identify what corrective or investigational action the Plan Sponsor took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects and to protect against any further Breaches;
- 5) Identify what steps the individuals who were subject to a Breach should take to protect themselves; and
- 6) Provide such other information, including a written report, as the Privacy Official may reasonably request.

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

MISCELLANEOUS PROVISIONS

CONDITIONS OF COVERAGE - The benefits described are available only when Covered Services are received on or after a Participant's effective date of coverage.

All Covered Services must be medically necessary, prescribed by a Physician or other professional provider, and rendered by a Physician (see Definitions).

Payment will be made for Covered Services according to the benefits in effect on the date the services are received.

A Participant has the right to select the provider of his choice. The Plan Sponsor has no responsibility for a provider's failure or refusal to render services to a Participant. Furthermore, the Plan Sponsor is not liable for anything the provider may or may not do.

NO VERBAL MODIFICATIONS - The Participant shall not rely on any oral description of the Plan, because the written terms in the plan documents always govern.

PLAN MODIFICATION AND AMENDMENT - Any amendment/modification of the Plan shall be in writing and signed by an officer of the Plan Sponsor pursuant to authorization by the Plan Sponsor's Board of Directors. The Plan Sponsor may modify or amend the Plan from time to time at its sole discretion. The amendments or modifications which affect the Participants will be communicated to them. The foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may have been made by the Plan Sponsor with the bargaining representatives of any Employees. If any amendment includes a change that constitutes a material reduction in services or benefits, Participants for whom that change is material will be informed of the change within 60 days of adoption of the change.

PLAN TERMINATION - Although the Plan Sponsor intends to maintain the Plan indefinitely, it reserves the right to terminate the Plan at any time, subject to any restrictions that may apply under applicable law or under a collective bargaining agreement to which an Employer is subject. Any termination of the Plan will be accomplished pursuant to a written authorization of the Plan Sponsor's Board of Directors. Upon termination, the rights of Participants to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to Participants.

WORKERS' COMPENSATION - If a participant is injured while at his/her place of employment or requires medical care as a result of employment, the participant should obtain care for such injuries through the arrangements provided by his/her Employer under Workers' Compensation laws. This Plan does not provide benefits for expenses which can be reimbursed under Workers' Compensation laws. However, benefits will be provided for expenses not covered by Workers' Compensation.

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

- 1) Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Participant of the Plan;
- 2) Attempting to file a claim for a Participant for services which were not rendered or Drugs or other items which were not provided;
- 3) Providing false or misleading information in connection with enrollment in the Plan; or

4) Providing any false or misleading information to the Plan.

STATEMENTS - All statements made by the Company or by a Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

Any Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

NO GUARANTEE OF EMPLOYMENT - Neither the Plan nor any provisions contained in the Plan shall be construed to be a contract between the Employer and the Employee, or consideration for, or an inducement of, the employment of any Employee by the Employer. Nothing contained in the Plan shall grant any Employee the right to be retained in the service of the Employer nor shall it limit in any way the right of the Employer to discharge or to terminate the service of any Employee at any time, without regard to the effect such discharge or termination may have on any rights under the Plan to the extent consistent with ERISA.

CONFORMITY WITH THE LAW - This Plan of benefits shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws. If any provision of this Plan is contrary to any applicable law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirements.

