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Purdue University

Purdue University Welfare Benefit Plan
Summary Plan Description

Effective
January 1, 2026

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SECTION I—INTRODUCTION

This document is a description of the Purdue University Welfare Benefit Plan (*Plan*). No oral interpretations can change this *Plan*. The *Plan* described is designed to protect *plan participants* against certain catastrophic health expenses. Terms which have special meanings when used in this *Plan* will be italicized. For a list of these terms and their meanings, please see the **Defined Terms** section of the summary plan description. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

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

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

This *Plan* is not a 'grandfathered health plan' under the *Patient Protection and Affordable Care Act (PPACA)*, also known as Health Care Reform. Please also refer to the *Plan's* wrap document(s). Questions regarding the *Plan's* status can be directed to the *Plan Administrator*. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272, or visit **www.dol.gov/ebsa/healthreform**.

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

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

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

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

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

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

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

A. Quick Reference Information Chart

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

QUICK REFERENCE INFORMATION	
Information Needed	**Whom to Contact**
Plan Administrator	Purdue University 2550 Northwestern Ave, Suite 1100 West Lafayette, IN 47906 1-765-494-2222
Medical Claims Administrator/Third Party Administrator (Medical) • *Claim* Forms (Medical) • Medical *Claims* • First-Level *Appeals* of *Post-Service Claims* • Eligibility for Coverage • Plan Benefit Information	Please refer to the *Plan's* wrap document(s).
Medical Management Administrator • *Pre-Certification*, Concurrent Review, and Case Management • First-Level *Appeals* of *Pre-Service Claims* • Any Clinical Determinations, Pre- and Post-Service, for Items Identified on the Pre-Certification List	AmeriBen Medical Management P.O. Box 9758 Boise, ID 83707 1-833-951-1394 (phone) 1-888-514-9030 (fax)
PPO Provider Network Names of *Physicians* & *Hospitals* • Network Provider Directory – see website	Anthem 1-800-502-6365 **www.anthem.com**
Pharmacy Benefits Manager • Retail *Network Pharmacies* • Mail Order (Home Delivery) *Pharmacy* • *Prescription Drug* Information & *Formulary* • Preauthorization of Certain Drugs • Reimbursement for *Non-Network* Retail *Pharmacy* Use • Specialty Pharmacy Program	**Retail** AffirmedRx 10200 Forest Green Blvd., Ste. 112 Louisville, KY 40223 1-877-828-1049 **https://affirmedrx.myrxplan.com/login** **Mail Order** Mark Cuban Cost Plus Drug Company and Amazon Pharmacy **Specialty** ArchimedesRx 1-888-318-0445 **Memberservices@archimedesrx.com**
Employee Assistance Program (EAP) • EAP Counseling and Referral Services	**https://www.purdue.edu/hr/Benefits/BehavioralHealth/MentalHealthResources/EAP.php**
HSA Vendor • HSA spending account	Please refer to the *Plan's* wrap document(s).
COBRA Administrator • Continuation Coverage	UnifyHR/WEX P.O. Box 67863 Fargo, ND 58108-6763 Phone: 1-800-519-8366 **COBRA@UnifyHR.com** Please also refer to the *Plan's* wrap document(s).
Obesity/Morbid Obesity Services • Bariatric Surgery • Certain Joint and Spinal Surgeries	Carrum Health 1-888-855-7806 **carrum.me/purdue**

B. Plan is Not an Employment Contract

Please refer to the *Plan's* wrap document(s).

C. Plan Administrator

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

Purdue University
2550 Northwestern Ave, Suite 1100
West Lafayette, IN 47906
1-765-494-2222

An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* shall appoint a new *Plan Administrator* as soon as reasonably possible.

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

Please also refer to the *Plan's* wrap document(s).

D. Duties of the Plan Administrator

Please refer to the *Plan's* wrap document(s).

E. Amending and Terminating the Plan

Please refer to the *Plan's* wrap document(s).

F. Plan Administrator Compensation

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

G. Fiduciary Duties

Please refer to the *Plan's* wrap document(s).

H. Type of Administration

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

I. Employer Information

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

Purdue University
2550 Northwestern Ave, Suite 1100
West Lafayette, IN 47906
1-765-494-2222
For the *Plan's* EIN please refer to the *Plan's* wrap document(s).

J. Plan Name

The name of the *Plan* is the Purdue University Welfare Benefit Plan.

K. Type of Plan

The *Plan* is commonly known as an employee welfare benefit plan. The *Plan* has been adopted to provide *plan participants* certain benefits as described in this document. The Purdue University Welfare Benefit Plan is structured as an ERISA exempt plan under ERISA Section 4(b).

L. Plan Year

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

M. Plan Effective Date

January 1, 2026

N. Plan Sponsor

The *employer* is the *Plan Sponsor*.

O. Third Party Administrator

The *Plan Administrator* has contracted with a *Third Party Administrator* (*TPA*) to assist the *Plan Administrator* with *claims* adjudication. The *TPA's* name, address, and telephone number are:

AmeriBen
P.O. Box 7186
Boise, ID 83707
1-833-782-9474

A *Third Party Administrator* is **not** a *fiduciary* under the *Plan*, except to the extent otherwise agreed upon in writing.

P. Employer's Right to Terminate

Please refer to the *Plan's* wrap document(s).

Q. Agent for Service of Legal Process

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

Plan Administrator
Purdue University
2550 Northwestern Ave, Suite 1100
West Lafayette, IN 47906
1-555-123-1234

SECTION II—EIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

A. Eligibility

Eligible Classes of Employees

Please refer to the *Plan's* wrap document(s).

Eligibility Requirements for Employee Coverage

Please refer to the *Plan's* wrap document(s).

Effective Date of Employee Coverage

Please refer to the *Plan's* wrap document(s). Active Employee Requirement

An *employee* must be an active *employee* (as defined by this *Plan*) for this coverage to take effect.

Eligible Classes of Dependents

Please refer to the *Plan's* wrap document(s).

Effective Date of Dependent Coverage

A *dependent's* coverage will take effect on the day that the eligibility requirements are met, the *employee* is covered under the *Plan*, and all enrollment requirements are met.

Ineligible Dependent(s)

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

1. other individuals living in the covered *employee's* home, but who are not eligible as defined
2. the legally separated or divorced former spouse of the *employee*
3. any person who is on active duty in any military service of any country
4. a person who is covered as an *employee* under the *Plan*
5. any other person not defined above in the subsection entitled Eligible Classes of Dependents

Restrictions on Elections

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

If both spouses are *employees*, their children will be covered as *dependents* of one (1) *employee*, but not of both.

If two (2) *employees* (spouses) are covered under the *Plan*, only the spouse with the lower salary tier may be covered as a *dependent* under the spouse on the higher salary tier. The spouse on the highest salary tier must be the primary *plan participant*. A spouse, within these stipulations, can be covered as an *employee* or as a *dependent*, but not both.

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

Please refer to the *Plan's* wrap document(s)s for if/when accumulators will transfer.

Eligibility Requirements for Dependent Coverage

A *dependent* of an *employee* will become eligible for *dependent* coverage on the first day that the *employee* is eligible for *employee* coverage and the family member satisfies the requirements for *dependent* coverage.

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

B. Tobacco Use Surcharge Notice

Your *employer* charges a tobacco use surcharge for *employees* and spouses who attest to tobacco or nicotine use in any form, including vaping, while on the sponsored medical *Plan*. You and your spouse will be asked to submit a Tobacco Attestation Form to qualify as tobacco/nicotine free. Refer to Purdue University for details and requirements pertaining to this provision.

C. Spousal Surcharge

A spouse who has access to another group health plan as an employee or primary individual and chooses to be covered as a *dependent* under this *Plan* will result in increased premiums for coverage. Refer to the *Plan Administrator* for details.

D. Enrollment

Enrollment Requirements

An *employee* must enroll for coverage for themselves and/or their *dependents* by completing the enrollment process along with the appropriate payroll deduction authorization.

Enrollment Requirements for Newborn Children

A newborn child, child placed for adoption, or newly adopted child of a covered *employee* is not automatically enrolled in this *Plan*, even if the covered *employee* has previously elected coverage for other *dependents*. An *employee* must complete an enrollment application within the timeframe shown in the Qualifying Events Chart subsection. Your *claim* for maternity expenses is not considered as *notification* to your *employer* for coverage.

If the newborn child (and covered parent) is not enrolled in this *Plan* on a timely basis, there will be no payment from the *Plan,* and the covered parent will be responsible for all costs. You will also have to wait until the next *open enrollment period* to add the child as a *dependent*.

E. Timely Enrollment

The enrollment will be timely if the completed form is received by the *Plan Administrator* no later than thirty-one (31) days after the person initially becomes eligible for coverage, or within the timeframe shown in the Qualifying Events Chart subsection for each type of special enrollment period.

Late Enrollment

An enrollment is late if it is not made on a timely basis or during a special enrollment period. *Late enrollees* and their *dependents* who are not eligible to join the *Plan* during the special enrollment period may join only during the *open enrollment period*.

The time between the date a *late enrollee* first becomes eligible for enrollment under the *Plan* and the first day of coverage is not treated as a *waiting period*. Coverage begins January 1 after completing the enrollment process.

F. Special Enrollment Rights

Federal law provides special enrollment provisions under some circumstances. If an *employee* is declining enrollment for themselves or their *dependents* (including a spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this *Plan* if there is a loss of eligibility for that other coverage (or if the *employer* stops contributing towards the other coverage). However, a request for enrollment must be made within the timeframe shown in the Qualifying Events Chart subsection after the coverage ends (or after the *employer* stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption, or placement for adoption or foster care, there may be a right to enroll in this *Plan*. However, a request for enrollment must be made within the timeframe shown in the Qualifying Events Chart subsection.

The special enrollment rules are described in more detail below. To request special enrollment or obtain more detailed information of these portability provisions, contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

G. Special Enrollment Periods

The *enrollment date* for anyone who enrolls under a special enrollment period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the *Plan* and the first day of coverage is not treated as a *waiting period*.

Individuals Losing Other Coverage, Creating a Special Enrollment Right

An *employee* or *dependent* who is eligible, but not enrolled in this *Plan*, may enroll if loss of eligibility for coverage meets any of the following conditions:

1. The *employee* or *dependent* was covered under a group health plan or had health insurance coverage at the time coverage under this *Plan* was previously offered to the individual.
2. If required by the *Plan Administrator*, the *employee* stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
3. The coverage of the *employee* or *dependent* who had lost the coverage was under COBRA and the COBRA coverage was exhausted or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because *employer* contributions towards the coverage were terminated.
4. The *employee* or *dependent* requests enrollment in this *Plan* no later than the timeframe shown in the Qualifying Events Chart subsection after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of *employer* contributions, described above.

For purposes of these rules, a loss of eligibility occurs if one (1) of the following occurs:

1. The *employee* or *dependent* has a loss of eligibility due to the *Plan* no longer offering any benefits to a class of similarly situated individuals (e.g., part-time *employees*).
2. The *employee* or *dependent* has a loss of eligibility as a result of legal separation, divorce, cessation of *dependent* status (such as attaining the maximum age to be eligible as a *dependent* child under the *Plan*), death, termination of employment, reduction in the number of hours of employment, or contributions towards the coverage were terminated.
3. The *employee* or *dependent* has a loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual).
4. The *employee* or *dependent* has a loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual.

Covered *employees* or *dependents* will not have a special enrollment right if the loss of other coverage results from either:

1. the *employee's* failure to pay premiums or required contributions
2. the *employee* or *dependent* making a fraudulent *claim* or an intentional misrepresentation of a material fact in connection with the *Plan*

Dependent Beneficiaries

If a *dependent* becomes eligible to enroll and the *employee* is not enrolled, the *employee* must enroll in order for the *dependent* to enroll.

If both of the following criteria are met, then the *dependent* (and if not otherwise enrolled, the *employee* and other eligible *dependents*) may be enrolled under this *Plan*:

1. The *employee* is a *plan participant* under this *Plan* (or has met the *waiting period* applicable to becoming a *plan participant* under this *Plan* and is eligible to be enrolled under this *Plan* but for a failure to enroll during a previous enrollment period).
2. A person becomes a *dependent* of the *employee* through marriage, birth, adoption, or placement for adoption or foster care.

The *dependent* special enrollment period is shown in the Qualifying Events Chart subsection. To be eligible for this special enrollment, the *dependent* and/or *employee* must request enrollment within the timeframe specified in the Qualifying Events Chart subsection.

H. Qualifying Events Chart

This chart is only a summary of some of the permitted health plan changes and is not all-inclusive. Please also refer to the *Plan's* wrap document(s).

Qualifying Event	Effective Date	Forms and Notification Must be Received Within:	You May Make the Following Changes(s)
Marriage	Date of event	thirty-one (31) days of marriage	Enroll yourself, if applicable Enroll your spouse and other newly acquired *dependents*
Divorce or annulment	Date of event	thirty-one (31) days of the date of final divorce decree or annulment	Coverage will terminate for your spouse Enroll yourself and *dependent* child(ren) if you, or they, were previously enrolled in your spouse's plan
Birth of your child	Date of event	sixty (60) days of birth	Enroll yourself Enroll the newborn child
Adoption, placement for adoption, *foster child*, or legal guardianship of a child	Date of event	thirty-one (31) days of adoption	Enroll yourself Enroll the newly adopted child
A change in employment status from part-time to full-time	Date of event	thirty-one (31) days of change in status	Enroll yourself, if applicable Enroll your new spouse and other eligible *dependents*
Spouse or covered *dependent* obtains coverage in another group health plan	Date of event	thirty-one (31) days of gain of coverage	Drop coverage for yourself, your spouse, or covered *dependent* children
Loss of other coverage, including COBRA coverage	Date of event	thirty-one (31) days of the date of loss of coverage	Enroll yourself, your spouse and eligible *dependent* children
Spouse's loss of coverage, including COBRA coverage	Date of event	thirty-one (31) days of the date of loss of coverage	Enroll your spouse and eligible *dependent* children Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse's plan
Eligibility for government-sponsored plan, such as *Medicare* (excluding the government-sponsored Marketplace)	Date of event	thirty-one (31) days of eligibility date	Drop coverage for the person who became entitled to *Medicare*, Medicaid, or other eligible coverage
CHIP Special Enrollment – loss of eligibility for coverage under a state Medicaid or CHIP program, or eligibility for state premium assistance under Medicaid or CHIP	Date of event	sixty (60) days of loss of eligibility or eligibility date	Enroll yourself, if applicable Add the person who lost entitlement to CHIP Drop coverage for the person entitled to CHIP coverage
Qualified Medical Support Order affecting a *dependent* child's coverage	Date listed on the notice	thirty-one (31) days of order	Enroll yourself, if applicable Enroll the eligible child named on *QMCSO*

I. Termination of Coverage

Rescission of Coverage

Please refer to the *Plan's* wrap document(s).

When Employee Coverage Terminates

Please refer to the *Plan's* wrap document(s).For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled **Continuation Coverage Rights Under COBRA**.

When Dependent Coverage Terminates

Please refer to the *Plan's* wrap document(s).For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled **Continuation Coverage Rights Under COBRA.**

J. Continuation During Periods of Employer-Certified Disability, Leave of Absence, or Layoff

A person may remain eligible for a limited time if active, full-time work ceases due to disability, *leave of absence,* or layoff. This continuance will end as follows:

1. for disability leave only: the date the *employer* ends the continuance
2. for *leave of absence* or layoff only: the date the *employer* ends the continuance

While continued, coverage will be that which was in force on the last day worked as an active *employee*. However, if benefits are reduced for others in the class, they will also be reduced for the continued person.

K. Continuation During Family and Medical Leave

Please refer to the *Plan's* wrap document(s).

L. Rehiring a Terminated Employee

Please refer to the *Plan's* wrap document(s).

M. Open Enrollment

Every year during the annual *open enrollment period*, covered *employees* and their covered *dependents* will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Every year during the annual *open enrollment period*, *employees* and their *dependents* who are *late enrollees* will be able to enroll in the *Plan*.

Benefit choices made during the *open enrollment period* will become effective January 1 and remain in effect until the next January 1 unless there is a special enrollment event or change in family status during the year (birth, death, marriage, , divorce, adoption, placement for foster care) or loss of coverage due to loss of a spouse's employment. To the extent previously satisfied, coverage *waiting periods* will be considered satisfied when changing from one benefit option under the *Plan* to another benefit option under the *Plan*.

Benefit choices for *late enrollees* made during the *open enrollment period* will become effective January 1.

A *plan participant* who fails to make an election during an active *open enrollment period* will no longer be covered under this *Plan*. A *plan participant* will automatically retain their present coverages during a passive *open enrollment period*. However, if an *employee* is enrolled in a health savings account (HSA) they are required to actively elect these benefits during the *open enrollment period* each year in order to retain their present coverage. *Plan participants* will receive detailed information regarding open enrollment from their *employer*.

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

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

Please also refer to the *Plan's* wrap document(s)s.

A. Surprise Billing Claims

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

1. *emergency services* in an emergency department of a hospital or independent freestanding emergency department provided by *non-network* providers or facility
2. services provided by a *non-network* provider at a *network* facility
3. *non-network* air ambulance services

The section below contains further information about how these *claim* categories apply to your *Plan* and are dependent on covered benefits.

B. No Surprises Billing Act Requirements

Emergency Services

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

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

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

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

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

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

Non-Network Services Provided at a Network Facility

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

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

1. items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a *physician* or non-physician practitioner

2. items and services provided by assistant surgeons, hospitalists, and intensivists
3. diagnostic services, including radiology and laboratory services
4. items and services provided by a *non-participating provider* if there is no *participating provider* who can furnish such item or service at such facility

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

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

1. by obtaining your consent and offering the required notice no later than seventy-two (72) hours prior to the delivery of services
2. the *notice* is given and consent is obtained on the date of the service, if you make an appointment within seventy-two (72) hours of the services being delivered

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

C. How Cost-Shares Are Calculated

Your *cost sharing amounts* for emergency services in an emergency department of a hospital or independent freestanding emergency department or for covered services received by a *non-network* provider at a *network* facility will be calculated as defined by the CAA, such as the lesser of billed charges or the median plan *network* contract rate (called the Qualifying Paying Amount or QPA) that we pay *network* providers for the geographic area where the covered service is provided if other calculation criteria does not apply. Any out-of-pocket cost you pay to a *non-network* provider for either these *emergency services* or for covered services provided by a *non-network* provider at a *network* facility will be applied to your *network out-of-pocket limit*. Cost-sharing for air ambulance services is based on the lesser of billed charges or the QPA.

D. Appeals

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

E. Transparency Requirements

Under your *Plan*, the following are provided as required by the CAA and/or TIC. Depending on how the *Plan* interacts with other entities, these may be provided from the *Third Party Administrator*, the *network*, Pharmacy Benefit Manager, and/or other stakeholders (ex. Customer Care or Member Services):

1. protections with respect to *surprise billing claims* by providers
2. estimates on what *non-network* providers may charge for a particular service
3. information on contacting state and federal agencies in case you believe a provider has violated the No Surprise Billing Act's requirements

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

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

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

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

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

F. Continuity of Care

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

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

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

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

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

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

SECTION IV—MEDICAL NETWORK INFORMATION

A. Network and Non-Network Services

Network Provider Information

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

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

Non-Network Provider Information

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

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

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

Provider Non-Discrimination

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

B. Choosing a Physician – Patient Protection Notice

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

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

C. Special Reimbursement Provisions

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

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

definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* the *Third Party Administrator* for a review of any *claim* that meets this definition.

3. **Providers Outside of Network Area.** If *non-network primary care physicians* or specialists are used because the necessary service or specialty is not in the *network* or is not reasonably accessible to the *plan participant* due to geographic constraints (as dictated by the *Plan*) , such *non-network* service or specialist care will be covered at *network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* the *Third Party Administrator* for a review of any *claim* that meets this definition.
4. **Transition of Care.** Transition of care is available for newly-hired *employees* or *employees* enrolling in the *Plan* as part of an acquisition. This provision applies to newly-acquired *employees* and their covered *dependents* that are currently under the care of a *non-network* provider for pregnancy, *outpatient* mental health office visits, cancer treatment, or care for any medical condition. If transitional care is appropriate, specific treatment by a *non-network* provider may be covered at the *network* level of benefits for ninety (90) days.

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

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

D. Blue Cross Blue Shield Global Core® Program

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

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core Service Center any time. They are available twenty-four (24) hours a day, seven (7) days a week. The toll free number is 1-800-810-2583. Or you can call them collect at 1-804-673-1177.

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

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

How Claims are Paid with Blue Cross Blue Shield Global Core

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

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

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

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

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

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

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

E. Network Information

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

Anthem

1-800-502-6365

www.anthem.com

All locations

NOTE: For those *plan participants* requiring services while traveling or residing outside the primary service area, please contact Anthem at 1-800-502-6365 or visit **www.anthem.com**.

SECTION V—SCHEDULE OF BENEFITS

A. Verification of Eligibility: 1-833-782-9474

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

B. Schedule of Benefits

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

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

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

C. Deductible Amount

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

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

D. Benefit Payment

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

All dollar and visit limits are combined for *network* and *non-network* services, unless otherwise noted.

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

E. Out-of-Pocket Limit

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

F. Diagnosis Related Grouping (DRG)

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

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

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

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

G. Co-Insurance

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

For *covered charges incurred* with a *non-network* provider for services covered as mandated under the Consolidated Appropriations Act of 2021, the *Plan* pays a specified percentage of *covered charges* at the *maximum allowable charge*. In those circumstances, you are responsible for the difference between the percentage the *Plan* pays and 100% of the billed amount, unless your *claim* is a *surprise billing claim*.

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

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

H. Co-Payments

In certain cases, instead of paying *co-insurance*, you must pay a specific dollar amount, as specified in the applicable Schedule of Medical Benefits. This amount for which you are responsible is known as a *co-payment* and is typically payable to the health care provider at the time services or supplies are rendered.

Unless otherwise stated in the applicable Schedule of Medical Benefits, *co-payments* are applied per provider per day (the highest applicable *co-payment* amount will apply).

Unless noted otherwise in the Special Comments column of the applicable Schedule of Medical Benefits, your *co-payments* apply toward satisfaction of the *out-of-pocket limit*.

I. Balance Bill

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

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

Non-network providers have no obligation to accept the *allowable charge*. You are responsible to pay a *non-network* provider's billed charges, even though reimbursement is based on the *allowable charge*. Depending on what billing arrangements you make with a *non-network* provider, the provider may charge you for full billed charges at the time of service or seek to *balance bill* you for the difference between billed charges and the amount that is reimbursed on a *claim*.

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

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

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

J. High Deductible Health Plan (HDHP)

A qualified *high deductible health plan* (*HDHP*) with a *health savings account* (*HSA*) provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help build savings for future medical expenses. The *Plan* gives you greater control over how health care benefits are used. An *HDHP* satisfies certain statutory requirements with respect to minimum *deductibles* and *out-of-pocket limits* for both individual and family coverage. These minimum *deductibles* and maximum *out-of-pocket limits* are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

How This Plan Works

This *Plan* features higher annual *deductibles* and *out-of-pocket limits* than other traditional health plans. With the exception *of preventive care*, you must meet the annual *deductible* before the *Plan* pays benefits. It is called a *high deductible health plan* or *HDHP*.

It is paired with a *health savings account* (*HSA*). You may elect to make pre-tax contributions from your paycheck to your *HSA* each pay period. The *HDHP* provides medical and *prescription drug* coverage, and the *HSA* provides a tax-free way to help you save for health expenses in retirement. The *HDHP* gives you flexibility and discretion to determine how to use your health care benefits.

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

Applying Expenses to the Deductible

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

K. Requirements for a Health Savings Account (HSA)

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

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

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

Qualified Medical Expenses

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

L. Schedule of Medical Benefits – Premier CDHP Option

	NETWORK PROVIDERS		NON-NETWORK PROVIDERS
	TIER 1	TIER 2	
Deductible, per Calendar Year The *network* and *non-network deductible* amounts do not accumulate towards each other. *Co-insurance* does not apply to the *deductible*. *Co-payments* and *prescription drug* charges apply to the *deductible*.			
Individual Plan	$1,700	$2,400	$4,900
Per *family unit*	$3,400	$4,800	$9,800
Family Unit - Non-Embedded Deductible If you are enrolled in the family option, there is not an individual *deductible* embedded in the *family unit deductible*. Before your *Plan* helps you pay for any of your medical bills, the entire amount of the *family unit deductible* must be met first. It can be met by one (1) family member or a combination of family members; however, there are no benefits (except for *preventive care*) until expenses equaling the *family unit deductible* amount have been *incurred*. **For example,** if you, your spouse, and child are on a family plan with a $3,400 *family unit* non-embedded *deductible* and the individual *deductible* is $1,700, and your child *incurs* $1,700 in medical bills, your *Plan* will NOT help pay subsequent medical bills until the *family unit deductible* of $3,400 has been met yet.			
Maximum Out-of-Pocket Limit, per Calendar Year The *out-of-pocket limit* includes *co-payments, co-insurance, deductibles,* and covered *prescription drug* charges. The *network* and *non-network out-of-pocket limits* do not accumulate towards each other.			
Individual Plan	$2,500	$3,650	$9,500
Per *family unit*	$5,000	$7,300	$19,000
Family Unit - Non-Embedded Out-of-Pocket Limit If you are enrolled in the *family unit* option, there is not an individual *out-of-pocket limit* embedded in the *family unit out-of-pocket limit*. Before your *covered charges* are payable at 100% (except for the charges excluded), the entire amount of the *family unit out-of-pocket limit* must be met first. It can be met by one (1) family member or a combination of family members. When a *family unit* reaches the *out-of-pocket limit*, *covered charges* for that *family unit* will be payable at 100% (except for the charges excluded) for the remainder of the *calendar year*.			
The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise. **NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the Plan:** 1. cost containment penalties 2. amounts over *the maximum allowable charges* 3. charges not covered under the *Plan* 4. *balance billed* charges			

Benefits shown as *co-payments* and *co-insurance* are listed for what the *plan participant* will pay.

COVERED SERVICES	NETWORK PROVIDERS		NON-NETWORK PROVIDERS	SPECIAL COMMENTS
	TIER 1	TIER 2		
General Percentage Payment Rule	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply.
Accidental Injury	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Advanced Imaging	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	Includes Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans, excluding services rendered in an emergency room setting. ***Pre-certification* is required.**
Allergy Services				
Allergy Testing	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Allergy Treatment	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Ambulance Service	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*		**Non-Emergency Ambulance Maximum:** $50,000 per occurrence Please refer to the **Medical Benefits** section, Covered Medical Charges, Ambulance, for a further description and limitations of this benefit. ***Pre-certification* is required for non-emergent air ambulance.**
Birthing Center	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Campus Clinics – Center for Healthy Living WL/NW/FW	$25 flat fee, applies to *deductible*		Not Applicable	
Cardiac Rehabilitation	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Chemotherapy Drugs/Infusions and Radiation Treatments	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	This benefit applies for all covered diagnoses. ***Pre-certification* is required for certain services within these categories.** Refer to Health Care Management Program, Pre-Certification for details.

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COVERED SERVICES	NETWORK PROVIDERS		NON-NETWORK PROVIDERS	SPECIAL COMMENTS
	TIER 1	TIER 2		
Chiropractic Treatment	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	*Spinal manipulations* apply to the chiropractic benefit level. **Calendar Year Maximum:** twenty-six (26) visits
Circumcision	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	Please refer to the **Medical Benefits** section, Covered Medical Charges, Circumcision, for a further description and limitations of this benefit.
Dental Injury	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	*Services rendered by a *non-network* dentist or oral surgeon will be covered at the Tier 2 *network* benefit level. Please refer to the **Medical Benefits** section, Covered Medical Charges, Dental Injury, for a further description and limitations of this benefit.
Diabetic Education	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Diabetic Supplies	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Diagnostic Testing	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Dialysis, Outpatient	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Durable Medical Equipment (DME)	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*		***Pre-certification* is required** for *DME* in excess of $1,500 purchase/rental price.
Emergency Room	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*		Emergency room treatment is limited to medical emergencies having sudden and unexpected onset requiring immediate care to safeguard the life of the *plan participant*.
Footwear				
Diabetic Shoes	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	**Calendar Year Maximum:** two (2) pairs or four (4) units
Foot Orthotics	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	Coverage limited to foot orthotics for conditions related to metabolic, peripheral vascular disease, post-surgical, or when medically necessary.
Hearing Exams, Diagnostic	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	

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COVERED SERVICES	NETWORK PROVIDERS		NON-NETWORK PROVIDERS	SPECIAL COMMENTS
	TIER 1	TIER 2		
Home Health Care	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	**Calendar Year Maximum:** one hundred twenty (120) visits, including private duty nursing ***Pre-certification* is required.**
Home Infusion	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Home Visits	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	Visits in the home (i.e. house calls) outside of a *home health care plan*.
Hospice Care	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Inpatient Hospital				
Physician Visits	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Room and Board	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	Limited to the semi-private room rate when such semi-private room rate is available. ***Pre-certification* is required.**
Lab and X-Ray	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Maternity				
Initial Office Visit	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	***Pre-certification* is required for certain services within these categories.** Refer to Health Care Management Program, Pre-Certification for details.
All Other Services	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Labor and Delivery	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Mental Disorders & Substance Use Disorder				
Inpatient	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	Includes residential treatment. ***Pre-certification* is required.**
Outpatient – Partial Hospitalization and Outpatient Intensive Day Treatment	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	***Pre-certification* is required** for partial hospitalization and intensive *outpatient* programs.
Outpatient – Office and Other	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Nutritional Counseling/Therapy	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	Coverage is limited to eating disorders only.

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COVERED SERVICES	NETWORK PROVIDERS		NON-NETWORK PROVIDERS	SPECIAL COMMENTS
	TIER 1	TIER 2		
Office Visit				
Primary Care Physician	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Specialist	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Oral Surgery	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	*Services rendered by a *non-network* dentist or oral surgeon will be covered at the Tier 2 *network* benefit level. Please refer to the **Medical Benefits** section, Covered Medical Charges, Oral Surgery, for a further description and limitations of this benefit.
Orthotic Appliances/Prosthetics	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	***Pre-certification* is required** for prosthetics.
Outpatient Observation Stays	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	After twenty-three (23) observation hours, a confinement will be considered at this benefit level. Prior to twenty-three (23) observation hours, benefits will pay at the applicable benefit level.
Outpatient Surgery	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	***Pre-certification* is required for certain surgical procedures.** Refer to Health Care Management Program, Pre-Certification for details.
Retail Clinics	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Rehabilitation Facility	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	**Calendar Year Maximum:** thirty (30) days ***Pre-certification* is required.**
Respiratory Therapy	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Routine Newborn Care	10% *co-insurance*, *deductible* waived	20% *co-insurance*, *deductible* waived	40% *co-insurance* after *deductible*	Routine newborn care is subject to the mother's *deductible* and *out-of-pocket limit*. If the mother is not covered under the *Plan*, then these expenses apply to the newborn's *deductible* and *out-of-pocket limit*.
Skilled Nursing Facility	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	**Calendar Year Maximum:** one hundred twenty (120) days ***Pre-certification* is required.**

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COVERED SERVICES	NETWORK PROVIDERS		NON-NETWORK PROVIDERS	SPECIAL COMMENTS
	TIER 1	TIER 2		
Telemedicine				
LiveHealth Online	20% *co-insurance*, after *deductible*		Not Covered	Telemedicine benefit provided through Anthem at **www.livehealthonline.com**.
Other	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	Visual consultations only.
Therapy Services				
Physical Therapy Occupational Therapy Speech Therapy	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	**Calendar Year Maximum:** fifty (50) visits per therapy type. Wound debridement services do not apply toward the Therapy Services maximum.
Urgent Care	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Vision Services				
Vision Exam, Diagnostic	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Vision Therapy	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	
Wigs	10% *co-insurance* after *deductible*	20% *co-insurance* after *deductible*	40% *co-insurance* after *deductible*	Over-the-counter wigs apply as Tier 2 *in-network*. Limited to hair loss related to chemotherapy, radiation therapy, burns, alopecia, behavioral health conditions or any other conditions necessitated by *disease* or *injury*. **Calendar Year Maximum:** Limited to one (1) unit per *plan participant*. Includes coverage for wigs purchased over the counter.

Premier CDHP Option

<table>
<tr><th rowspan="2">COVERED SERVICES</th><th colspan="2">NETWORK PROVIDERS</th><th rowspan="2">NON-NETWORK PROVIDERS</th><th rowspan="2">SPECIAL COMMENTS</th></tr>
<tr><th>TIER 1</th><th>TIER 2</th></tr>
<tr><td colspan="5">PREVENTIVE CARE

If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), the IRS Safe Harbor preventive services list, or preventive care for children under Bright Future guidelines, then the service is covered at 100% when performed by a network provider at a Routine Wellness Care visit. If there are no network providers who perform or provide the service, then non-network providers will be covered at the network level. For more information about preventive services please refer to the following websites:

https://www.healthcare.gov/coverage/preventive-care-benefits/
http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
www.hrsa.gov

Safe Harbor Services:
https://www.irs.gov/pub/irs-drop/n-04-23.pdf
https://www.irs.gov/pub/irs-drop/n-19-45.pdf

Non-Preventive Care services which are ordered or performed at a Routine Wellness Care visit are not considered under the Preventive Care benefit. Those services will apply to their applicable benefit level or exclusion as appropriate.

The Plan does not limit all federally mandated preventive care services to age/frequency/gender guidelines as outlined by the USPSTF.</td></tr>
<tr><td>Routine Wellness Care</td><td>0% co-insurance, deductible waived</td><td>0% co-insurance, deductible waived</td><td>40% co-insurance after deductible</td><td>Services include routine physical exam, labs and x-rays, immunizations, gynecological exam, pap smear, PSA test, 2D and 3D mammogram, colorectal cancer screening, blood work, bone density testing, and shingles vaccine.

Please refer to the Medical Benefits section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.</td></tr>
<tr><td>Breastfeeding Pump and Supplies</td><td colspan="3">0% co-insurance, deductible waived</td><td>Breastfeeding support and supplies.

Breast pumps purchased over the counter will be covered at the network rate.</td></tr>
<tr><td>Contraceptive Services</td><td>0% co-insurance, deductible waived</td><td>0% co-insurance, deductible waived</td><td>40% co-insurance after deductible</td><td>Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion.

Benefit Limitations: Services are available to all female plan participants.</td></tr>
</table>

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

M. Schedule of Prescription Drug Benefits – Premier CDHP Option

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

Prescription drug charges do apply to the Tier 2 medical *network deductible*.
Prescription drug charges do apply to the Tier 2 medical *network out-of-pocket* maximum.

Benefits shown as *co-payments* and *co-insurance* are listed for what the *plan participant* will pay.

	NETWORK	NON-NETWORK
Retail Pharmacy Option – Thirty (30) Day Supply		
Level 1 – Preventive Low-Cost Generic Drugs	0% *co-insurance*, *deductible* waived	Prescriptions are only covered at participating *pharmacies*.
Level 1 – Non-Preventive Low-Cost Generic Drugs	Actual Cost: $10 maximum after *deductible*	Prescriptions are only covered at participating *pharmacies*.
Level 2 – Non-Preventive Higher Cost Generics & Preferred Brand Name Drugs	35% *co-insurance* up to $50 after *deductible*	Prescriptions are only covered at participating *pharmacies*.
Level 3 – Non-Preventive Highest Cost, Mostly Brand Name Drugs	50% *co-insurance* up to $75 after *deductible*	Prescriptions are only covered at participating *pharmacies*.
Level 4 – Non-Preventive Highest Cost, Mostly Brand Name & Specialty Drugs	55% *co-insurance* up to $250 after *deductible*	Prescriptions are only covered at participating *pharmacies*.
Retail Pharmacy Option – Ninety (90) Day Supply		
Level 1 – Non-Preventive Low-Cost Generic Drugs	Actual Cost: $20 maximum after *deductible*	Prescriptions are only covered at participating *pharmacies*.
Level 2 – Non-Preventive Higher Cost Generics & Preferred Brand Name Drugs	35% *co-insurance* up to $100 after *deductible*	Prescriptions are only covered at participating *pharmacies*.
Level 3 – Non-Preventive Highest Cost, Mostly Brand Name Drugs	50% *co-insurance* up to $150 after *deductible*	Prescriptions are only covered at participating *pharmacies*.
Level 4 – Highest Cost, Mostly Brand Name & Specialty Drugs	Not Applicable	Not Applicable
Mail Order Pharmacy Option – Ninety (90) Day Supply		
Level 1 – Non-Preventive Low-Cost Generic Drugs	Actual Cost: $20 maximum after *deductible*	Not Applicable
Level 2 – Non-Preventive Higher Cost Generics & Preferred Brand Name Drugs	35% *co-insurance* up to $100 after *deductible*	Not Applicable
Level 3 – Non-Preventive Highest Cost, Mostly Brand Name Drugs	50% *co-insurance* up to $150 after *deductible*	Not Applicable
Level 4 – Highest Cost, Mostly Brand Name & Specialty Drugs	Not Applicable	Not Applicable

Certain *preventive care prescription drugs* (including generic contraceptives) received by a *network pharmacy* are covered at 100% and the *deductible/co-payment/co-insurance* (if applicable) is waived. Any *prescription* listed on the Affordable Care Act (ACA) list will be covered at 100%, not subject to the *deductible*. Any medication listed on the AffirmedRx Preventive List will not be subject to the *deductible* but will be subject to the applicable *co-payment* or *co-insurance*. These lists are subject to change at any time, and *plan participants* are encouraged to refer to the list prior to having *prescriptions* filled.

Please note: your doctor must write a *prescription* for *preventive services* to be covered by the *prescription drug* benefit, even if they are listed as over-the-counter.

Please refer to the following websites for information on the types of payable *preventive care prescription drugs*: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**.

The *Plan* also covers certain Safe Harbor medications at the preventive rate. For a complete list of preventive and Safe Harbor medications, refer to the AffirmedRx list at **https://affirmedrx.myrxplan.com/login.**

Claims for reimbursement of *prescription drugs* are to be submitted to the Pharmacy Benefits Manager at the address listed in the Quick Reference Information Chart.

NOTE: For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the Drug Coverage List, which is incorporated by reference and is available from your *employer* or the Pharmacy Benefits Manager as listed in the Quick Reference Information Chart.

N. Schedule of Transplant Services – Premier CDHP Option

The transplant benefits are considered under the following benefit structure. Refer to the **Transplant Program** section of this summary plan description for additional information on transplant services coverage.

Benefits shown as *co-insurance* are listed for what the *plan participant* will pay.

COVERED SERVICES	NETWORK BLUE DISTINCTION CENTER (BDC) OR BDC+		SPECIAL COMMENTS
	TIER 1	TIER 2	
TRANSPLANTS			
Organ Transplants	10% *co-insurance* after *deductible*	25% *co-insurance* after *deductible*	Refer to the **Transplant Program** section for a further description and limitations of this benefit. All other related services will pay at the applicable benefit level. Refer to the **Transplant Program** section for a further description and limitations of this benefit and any associated covered travel expenses. **Donor Search Limitation:** $30,000 per transplant per *plan participant*. ***Pre-certification* is required.**
Travel	10% *co-insurance* after *deductible*	25% *co-insurance* after *deductible*	**Benefit Maximum:** $10,000 per transplant **Lodging Limitation:** $50 per day Refer to the **Medical Benefits** section for a further description and limitations of this benefit and any associated covered travel expenses.

SECTION VI—MEDICAL BENEFITS

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

A. Covered Medical Charges

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

1. **Accidental Injuries.** Services and supplies to treat *accidental injuries*. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
2. **Adoptive Cell Therapy.** For FDA approved adoptive cell therapy such as chimeric antigen receptor T-cell (CAR T) therapy along with associated services and supplies. ***Pre-certification* is required**.
3. **Advanced Imaging.** Charges for advanced imaging, including Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans. Charges include the readings of these medical tests/scans. ***Pre-certification* is required.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
4. **Allergy Services.** Charges for allergy testing and the cost of the resultant serum preparation (antigen) and its administration, when rendered by a *physician* or in the *physician's* office. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
5. **Ambulance.** Benefits will be provided for licensed ground, air, and water ambulance services used to transport you from the place where you are *injured* or stricken by *illness* to the nearest accredited general *hospital* with adequate facilities for treatment.

   Inter-facility transport is available to a *network hospital* after you have been stabilized at a *non-network hospital* or to the nearest accredited general *hospital* with adequate facilities for treatment as deemed *medically necessary*.

   Charges for services requested for a licensed ground, air, or water ambulance service, when the patient is not transported, will not be covered by the *Plan* unless it is a true emergency. Services for chartered flights will not be covered by the *Plan*. ***Pre-certification* is required for non-emergent air ambulance.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
6. **Anesthetics.** Includes anesthetic, oxygen, intravenous injections/solutions, and the administration of these items.
7. **Blood.** Non-replaced blood, blood plasma, cord blood harvesting and storage as deemed *medically necessary*, blood derivatives, and their administration and processing.
8. **Cardiac Rehabilitation.** Cardiac rehabilitation as deemed *medically necessary*, provided services are rendered in a *medical care facility* as defined by this *Plan*. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

   Coverage will be limited to phases one (1), two (2), and three (3).
9. **Chemotherapy/Radiation.** Radiation or chemotherapy and treatment with radioactive substances, including materials and services of technicians. ***Pre-certification* is required for certain services within these categories. Refer to Health Care Management Program for details.**
10. **Chiropractic.** Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.
11. **Circumcision.** Circumcision, both routine and *medically necessary*, covered for all ages.
12. **Clinical Trials.** This *Plan* will cover routine patient costs for a *qualified individual* participating in an *approved clinical trial* , as demonstrated via a signed consent form or proof of enrollment, that is conducted in connection with the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an *investigational* new drug application reviewed by the Food and Drug Administration, or is exempt from *investigational* new drug application requirements. Refer to the Medical Plan Exclusions subsection for a further description and limitations of this benefit.

13. **Contraceptives.** Injections, implants, devices, and associated *physician* charges are covered under the *Preventive Care* provision of this *Plan*. Self-administered contraceptives (not over-the-counter), are covered under the **Prescription Drug Benefits** section of this *Plan*.
14. **Court-Ordered Treatment.** Any treatment of a *plan participant* in a public or private *institution* as the result of a court order due to a criminal offense, including *health or substance use disorder holds* or services.
15. **Dental Injuries.** *Injury* to or care of the mouth, teeth, gums, and alveolar processes will be *covered charges* under this *Plan* only if that care is for the following oral *surgical procedures*:

    a. *emergency* repair due to *injury*

    b. *surgery* needed to correct *accidental injuries* to the jaws, cheeks, lips, tongue, floor, and roof of the mouth

    Services rendered by a *non-network* dentist or oral surgeon will be covered at the Tier 2 *network* benefit level.

    NOTE: No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease*, and preparing the mouth for fitting of or continued use of dentures.
16. **Diabetic Education.** Services and supplies used in *outpatient* diabetes self-management programs are covered under this *Plan* when they are provided by a *physician*. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
17. **Diagnostic Testing.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
18. **Dialysis.** If you are diagnosed with a condition requiring dialysis, you may be able to enroll in *Medicare*. Upon beginning dialysis treatments, *Medicare*, if applicable, will coordinate benefits with the *Plan* as the secondary payer for months four (4) through thirty-three (33) of the coordination period while you are receiving dialysis treatments. Your *non-network outpatient* dialysis medical *claims* will be considered at the 85th percentile. The *Plan* will not enroll you in *Medicare*; it is your decision and your responsibility to enroll in *Medicare*, if applicable. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
19. **Durable Medical Equipment (DME).** The total rental fee for *durable medical equipment* will not exceed the purchase price of the equipment. If the purchase price is not available, rental is allowed for the lifetime of the equipment. Repair, delivery, set-up, and education charges pertaining to DME are covered.

    ***Pre-certification* is required when the purchase and/or rental price is expected to exceed $1,500.**

    Replacement of purchased equipment is covered if either:

    a. the replacement is needed because of a change in your physical condition

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

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

    The following items will be considered under the DME benefit:

    a. **Diabetic Equipment.** Includes insulin pumps and supplies. For additional diabetic supplies, refer to the **Prescription Drug Benefits** section of this *Plan*.

       Visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of diabetic equipment and supplies related *preventive care* benefits.

    b. **Implantable Hearing Devices.** Charges for services, supplies including batteries, and hearing exams in connection with implantable hearing devices, including, but not limited to, cochlear implants and exams for their fitting. Benefits include aural therapy in connection with covered implantable hearing devices and apply to the Speech Therapy benefit level. See the Speech Therapy benefit in the applicable Schedule of Medical Benefits subsection for any applicable benefit maximum.

    c. **Oxygen.** Oxygen and its administration, including oxygen concentrators. Oxygen concentrators are not subject to purchase price requirements.

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.
20. **Family History.** Charges related to services provided with a diagnosis of family history, including as covered under applicable federal law.
21. **Foot Care.** Treatment for metabolic or peripheral-vascular *disease,* plantar fasciitis, neuromas, nail bed removal, or cutting/surgical procedures when *medically necessary* and not otherwise excluded. Non-custom molded foot orthotics are not covered. *Covered charges* and any applicable limitations for footwear will be payable as shown in the applicable Schedule of Medical Benefits.

22. **Gender.** Services will be considered under the applicable benefit level and limited as any other service outlined in the plan document. Services will not be limited based on an individual's documented gender.

23. **Genetic/Genomic Testing and Counseling.** Genetic and genomic testing to identify the potential for, or existence of, a medical condition and/or to examine abnormalities in groups of genes to aid in designing specific treatment options for an individual's condition as mandated by PPACA or as *medically necessary*.

    ***Pre-certification* is required.**

    Refer to the **Federal Notices** section for the statement of rights under the Genetic Information Nondiscrimination Act of 2008 (GINA).

24. **Hearing Exam.** Charges for a diagnostic hearing exam. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

25. **Home Health Care.** Charges for *home health care services and supplies* are covered only for care and treatment of an *illness* or *injury* when *hospital* or *skilled nursing facility* confinement would otherwise be required. The diagnosis, care, and treatment must be certified by the attending *physician* and be contained in a *home health care plan*.

    a. Benefit payment for nursing, home health aide, and therapy services are subject to the home health care limit shown in the applicable Schedule of Medical Benefits.

    b. A home health care visit will be considered a periodic visit by a *physician* acting within the scope of their license and/or as defined under *home health care services*.

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

26. **Home Infusion Therapy.** Home infusion therapy does not apply to the home health care maximum. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

27. **Home Visits.** When a provider visits the home for covered services, commonly known as a 'house call.' This is separate from home health care and therapy done in the home. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

28. **Hospice Care.** *Hospice care services and supplies* for *plan participants* with a life expectancy up to twelve (12) months, with disease modifying treatment allowed. Services must be rendered by a state-licensed *hospice care agency* and included in a written *hospice care plan* established and periodically reviewed by the attending *physician*. The *physician* must certify the *plan participant* is terminally *ill* and that *hospital* confinement would be required in the absence of the hospice care. The *hospice care plan* shall also describe the services and supplies for palliative care and treatment to be provided to the *plan participant* by the *hospice care agency*. Benefits are provided for:

    a. medical supplies

    b. visits by a *physician*

    c. bereavement counseling services for the hospice patient's immediate family (covered spouse and/or other covered *dependents*)

       Bereavement services must be furnished within one (1) year after the patient's death.

       NOTE: Bereavement counseling in connection with the *Plan's hospice care services* does **not** require *pre-certification*.

    d. respite care for *plan participants* with a life expectancy up to twelve (12) months, with disease modifying treatment allowed

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

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

    a. Private room charges will be paid at the semi-private room rate when such semi-private room rate is available.

    b. Charges for an *intensive care unit* stay do not apply to the semi-private room rate.

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

The *plan participant* is under age nineteen (19).

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

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

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

30. **Infertility.** Services include office visits and initial *diagnostic testing*.
31. **Injections and Infusion Therapy (Other).** Benefits are available for injections and infusion therapies received in an office setting or other covered facility only when not available through Archimedes.
32. **Laboratory Studies.** *Covered charges* for diagnostic lab testing and services. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
33. **Lenses.** The initial purchase of eyeglasses, contact lenses, or intraocular lenses per surgery for the following conditions:
    a. following cataract surgery
    b. damaged lens due to eye trauma
    c. congenital cataract
    d. congenital aphakia
    e. lens subluxation/displacement
    f. anisometropia of two (2) diopters or greater, and uncorrectable vision with the use of glasses or contacts
    g. replacement of a previously implanted intraocular lens due to anatomical change, inflammatory response, or mechanical failure
34. **Mastectomy Bras and Camisoles.** Mastectomy bra and camisole purchases will be limited to two (2) total items per *plan participant* per *calendar year*.
35. **Maternity.** *Pregnancy* and complications of *pregnancy* shall be covered as any other *illness* for the *employee* or spouse. *Dependent* child *pregnancy* is covered. Benefits include pre-and post-natal care, obstetrical delivery, caesarean section, miscarriage, and complications resulting from the *pregnancy*.

    NOTE: Breastfeeding maintenance, breast milk storage supplies, pump parts, and other supplies are also available as outlined in the applicable Schedule of Medical Benefits. Lactation counseling will be paid as other preventive services.

    Visit **https://www.healthcare.gov/coverage /preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations** for a current listing of required *pregnancy*-related *preventive care* benefits.

    Delivery and hospitalization stay may be subject to *pre-certification* if over the standards set forth in the Newborns' and Mothers' Health Protection Act. Refer to the **Federal Notices** section for the statement of rights under the Newborns' and Mothers' Health Protection Act for certain protections mothers and newborns have regarding *hospital* stays.
36. **Medical Foods.** Enteral (tube feedings) and parenteral (intravenous/IV) medical foods are considered a *covered charge*. Medical foods taken orally are not covered under the *Plan*, except for PKU formula.
37. **Medical Supplies.** Charges for surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations. Also included are supplies and dressings in instances such as surgical wounds, cancer, burns, diabetic ulcers, colostomy bags and catheters, ostomy supplies, and surgical and orthopedic braces, unless covered under the **Prescription Drug Benefits** section. Jobst/compression stockings are limited to four (4) pair or eight (8) units per *calendar year*.

    Visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of medical supplies related *preventive care* benefits.
38. **Mental Disorders and Substance Use Disorder.** Coverage for mental health treatments are considered the same as benefits provided for other medical conditions. *Inpatient* and *outpatient* treatment for *mental*

disorders, including counseling, will be eligible when rendered by a licensed psychiatrist or licensed psychologist or when rendered by a *physician* as defined. Includes *applied behavioral analysis* (*ABA*) therapy and testing, psychiatric day treatment, residential treatment, partial hospitalization, and intensive *outpatient* programs. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

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

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

39. **Midwife Services.** Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of their license. This *Plan* will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries.
40. **National/Public Health Emergency.** In the event of a declared National Health Emergency (or Public Health Emergency), the *Plan* will offer coverage as mandated for the conditions as required by federal regulation. This provision shall override any potentially conflicting, specific exclusions, defined terms, or other *Plan* provisions as necessary to provide, and limited to, any mandated services as outlined in the national and/or public health emergency, and corresponding regulation(s). Such coverage shall remain in effect until the national and/or public health emergency, as declared by the governing federal agency, has ended.
41. **Neuropsychological Testing.** Tests used to evaluate patients who have experienced a traumatic brain injury, brain damage, or organic neurological problems (e.g., dementia). May also be used to evaluate the progress of a patient who has undergone treatment or rehabilitation for a neurological *injury* or *illness*.
42. **Obesity/Morbid Obesity.** Screening, counseling, other care or treatment of obesity (except for weight loss programs) are covered under the *Plan*. Obesity charges are covered for surgical treatment, i.e. bariatric *surgery*, including, but not limited to, gastric bypass, stapling and intestinal bypass, and lap band *surgery*, including reversals.
43. **Oral Surgery.** Care of the mouth, teeth, gums, and alveolar processes will be a *covered charge* under this *Plan* only if that care is for the following oral *surgical procedures*:

    a. biopsies for non-dental lesions

    b. excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth

    c. external incision and drainage of soft tissue including cellulitis

        i. this coverage does not include odontogenic cysts or abscesses

    d. fracture of facial bones

    e. incision of sensory sinuses, salivary glands, or ducts

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

    g. orthognathic surgery/LeFort procedures to correct malposition in the bones of the jaw

    h. removal of bony impacted teeth

    i. reduction of dislocations and excision of *temporomandibular joints (TMJ)* or myofascial pain

    Services rendered by a *non-network* dentist or oral surgeon will be covered at the *network* benefit level.

    NOTE: No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease,* and preparing the mouth for fitting of or continued use of dentures.
44. **Orthotic Appliances.** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints, cranial helmets, or other appliances which are required for support for an *injured* or deformed part of the body as a result of a disabling congenital condition or an *injury* or *illness*.

    Replacement of purchased equipment is covered if either:

    a. the replacement is needed because of a change in your physical condition

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

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

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

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

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

    b. If multiple unrelated *surgical procedures* are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the *maximum allowable charge* for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the *maximum allowable charge* allowed for that procedure.

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

47. **Pre-Admission Testing.** Includes diagnostic labs, x-rays, and EKGs that you obtain on an *outpatient* basis prior to your scheduled admission to the *hospital*. You should make sure your *hospital* will accept the results of these tests.

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

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

    b. **Colorectal Cancer Screening.**

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

    d. **Gynecological Exam.**

    e. **Mammogram.**

    f. **Lactation Counseling.**

    g. **Pap Smear.**

    h. **Prostate Specific Antigen (PSA) Test.**

    i. **Immunizations.** Pediatric and adult preventive vaccinations, inoculations, and immunizations, as recommended by the Centers for Disease Control and Prevention (CDC)

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

    j. **Preventive Lab and X-Ray.** Laboratory and x-ray services related to routine examinations.

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

    l. **Tobacco Cessation.** Education, counseling, and behavioral intervention services provided by a *physician* for smoking/vaping cessation up to two (2) attempts per *calendar year*, consisting of four (4) visits lasting ten (10) minutes each.

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

    a. **https://www.healthcare.gov/coverage/preventive-care-benefits/**

b. **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**

c. **https://www.irs.gov/pub/irs-drop/n-04-23.pdf**

d. **https://www.irs.gov/pub/irs-drop/n-19-45.pdf**

49. **Prosthetic Devices.** The initial purchase of artificial limbs, eyes, and breast prostheses, including service and repair of an artificial limb, eye, or breast prosthesis.

    Replacement of purchased equipment is covered if either:

    a. the replacement is needed because of a change in your physical condition

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

    ***Pre-certification* is required.**

    The following devices will be considered under the prosthetic benefit:

    a. **Sleep Apnea Oral Devices.**

    b. **TMJ Oral Devices.**

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

50. **Reconstructive Surgery.** *Reconstructive surgery* expenses are covered in the following circumstances:

    a. when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part

    b. to correct damage caused by an *accidental injury*

    c. for breast *reconstruction* following a total or partial *mastectomy*, as follows:

    d. *reconstruction* of the breast on which the *mastectomy* has been performed

    e. *surgery* and *reconstruction* of the other breast to produce a symmetrical appearance

    f. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

    All other *reconstructive surgeries* will be covered under the *Plan* when *medically necessary*, except as otherwise excluded herein.

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

51. **Routine Newborn Care.** Routine well-baby care is care while the newborn is *hospital*-confined after birth and includes *room and board* and other normal care for which a *hospital* makes a charge.

    This coverage is only provided if the newborn child is an eligible *dependent* and a parent either:

    is a *plan participant* who was covered under the *Plan* at the time of the birth

    enrolls (as well as the newborn child if required) in accordance with the Special Enrollment Periods provisions with coverage effective as of the date of birth

    The benefit is limited to *allowable charges* for well-baby care after birth while the newborn child is *hospital* confined as a result of the child's birth. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

52. **Screening Services.**

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

54. **Skilled Nursing Facility.** The *room and board* and nursing care furnished by a *skilled nursing facility* will be payable if and when:

    a. The patient is confined as a bed patient in the facility.

    b. The attending *physician* certifies that the confinement is needed for further care of the condition that caused the *hospital* confinement.

c. The attending *physician* completes a treatment plan which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the *skilled nursing facility*.

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

55. **Sleep Disorders/Sleep Studies.** Care and treatment for sleep disorders, including sleep studies performed in the home.
56. **Sterilization.** Services for vasectomy or other voluntary sterilization procedures for male *plan participants*. Female sterilization and family planning counseling is covered under the Preventive Care provision of this *Plan*. The *Plan* does not cover the reversal of voluntary sterilization procedures, including related follow-up care.
57. **Surgery.** Benefits for the treatment of *illnesses* and *injuries,* including fractures and dislocations, are covered for the surgeon, assistant surgeon, anesthesiologist, and surgical supplies. ***Pre-certification* is required for certain surgical procedures.** Refer to **Health Care Management Program**, Pre-Certification for details.
58. **Temporomandibular Joint Syndrome (TMJ).** Benefits for medical or dental services for treatment of *temporomandibular joint* disorders.
59. **Therapy Services.** Services include the following therapy types rendered on an *inpatient* or *outpatient* basis:

    a. **Physical Therapy.** Benefits include massage therapy, when rendered as part of covered physical therapy, and aquatic therapy.

    b. **Occupational Therapy.**

    c. **Speech Therapy.** Benefits include aural therapy following a covered implantable hearing device.

    Therapy in the home applies to the *outpatient* Therapy Services maximum unless rendered as part of a *home health care plan*. Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.

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

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

60. **Travel Expenses.** Covered travel and lodging expenses are only covered for services related to transplants. The *plan participant* must be receiving services at a designated *Blue Distinction Center* (*BDC*) or *BDC+* facility.

    Eligible expenses for travel and lodging up to a combined maximum of $10,000 for the *plan participant* (while not a *hospital inpatient*) and companion(s) who are traveling on the same day(s) to and/or from the site of treatment for the purposes of an evaluation, the procedure, and/or necessary post-discharge follow-up . Benefits are paid at a per diem (per day) rate of up to $50 per day for the *plan participant* or up to $100 per day for the *plan participant* plus one (1) companion. If the *plan participant* is an enrolled *dependent* and minor child, the transportation expenses of two (2) companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $50 per day.

    Travel and lodging expenses are only available if the *plan participant* lives more than seventy (75) miles from the designated *network* facility. These benefits will be reimbursed upon the submission to the *Plan* of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service provider. Refer to the **Claims and Appeals** section for instructions on how to submit a *claim* for reimbursement. The listed expenses must be *incurred* within five (5) days prior to the procedure and one hundred twenty (120) days after the procedure. Applicable travel expenses will also be covered during the transplant evaluation period. The *Plan Administrator* reserves the right not to reimburse any such expenses that it, in its sole discretion, deems inappropriate, excessive, or not in keeping with the intent of this provision. Examples of eligible travel expenses may include airfare (at coach rate), taxi or ground transportation, or mileage reimbursement at the IRS rate for the most direct route between the *plan participant's* home and the designated *network* facility. Refer to the Medical Plan Exclusions subsection for a further description and limitations of eligible travel expenses for reimbursement.

61. **Virtual Visits.** Services rendered electronically, performed by providers other than the *Plan's* telemedicine vendor, when performed visually for covered medical and/or mental/behavioral health services. Telephonic consultations (audio only) are not covered.
62. **Vision Services.** Benefits are available for medical vision examinations, including a contact lens fitting. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
63. **Wigs**. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

64. **X-Rays.** Diagnostic x-rays.

B. Medical Plan Exclusions

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

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

1. **Abortion.** Services, supplies, care, treatment, or drugs in connection with an abortion unless the life of the mother is endangered by the continued *pregnancy* or the *pregnancy* is the result of rape, incest, or molestation.
2. **Alcohol.** Services, supplies, care, or treatment to a *plan participant* for an *injury* or *illness* arising from taking part in any activity made illegal due to the use of alcohol. Expenses will be covered for *injured plan participants* other than the person partaking in any activity made illegal due to the use of alcohol, and expenses may be covered for *substance use disorder* treatment as specified in this *Plan*, if applicable.
3. **Alternative Medicine.** Charges for the following, including related drugs, are excluded under this *Plan*: holistic or homeopathic treatment, naturopathic services, thermography, acupuncture, acupressure, aromatherapy, hypnotism, massage therapy except when rendered as part of covered physical therapy, rolfing (holistic tissue massage), art therapy, music therapy, dance therapy, horseback therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.
4. **Armed Forces.** Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any *plan participant* in the armed forces of a government.
5. **Athletic Training.**
6. **Biofeedback.**
7. **Cardiac Rehabilitation.** Cardiac rehabilitation phase four (4).
8. **Chelation Therapy.** Except for lead poisoning.
9. **Clinical Trials.** The following items are not routine patient costs and are excluded from *approved clinical trial* coverage under this *Plan*:
    a. the *investigational* item, device, or service, itself
    b. items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the patient
    c. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

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

    The *Plan* does not cover routine patient care services that are provided outside of this *Plan's* health care provider *network* unless *non-network* benefits are otherwise provided under this *Plan*.
10. **Complications from a Non-Covered Service.** Care, services, or treatment required as a result of complications from a treatment not covered under the *Plan*. Complications from a non-covered abortion are covered.
11. **Cosmetic.** *Cosmetic* procedures and attendant hospitalization, except for newborn children or due to trauma or *disease*, done for aesthetic purposes and not to restore an impaired function of the body. Complications or subsequent *surgery* related in any way to any previous *cosmetic* procedure shall not be covered, regardless of *medical necessity*.
12. **Counseling.** Benefits for counseling in the absence of *illness* or *injury*, including, but not limited to, premarital or marital counseling; education, social, or recreational therapy; sex or interpersonal relationship counseling; counseling for the purpose of family problems, or counseling provided by *plan participant's* friends, *employer*, school counselor, or schoolteacher. Family and group counseling is covered when rendered for an otherwise covered diagnosis.
13. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, or *custodial care*.
14. **Dental Care.** Normal dental care benefits, including any dental, gum treatments, or oral *surgery* except as otherwise specifically provided herein.

15. **Educational or Vocational Testing.** Services for educational or vocational testing or training. Educational services such as asthma self-management education, and Lamaze, except as listed herein.
16. **Error.** Any charge for care, supplies, treatment, and/or services that are required to treat *injuries* that are sustained, or an *illness* that is contracted, including infections and complications, while the *plan participant* was under, and due to, the care of a provider wherein such *illness*, *injury*, infection, or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the *Plan Administrator*, in its sole discretion, unreasonably gave rise to the expense.
17. **Examinations.** Any health examination required by any law of a government to secure insurance or school admissions (including sports physicals) or professional or other licenses, except as required under applicable federal law.
18. **Excess Charges.** Any charge for care, supplies, treatment, and/or services that are not payable under the *Plan* due to application of any *Plan* maximum or limit, charges which are in excess of the *maximum allowable charge*, or services not deemed to be *reasonable* or *medically necessary*, based upon the *Plan Administrator's* determination as set forth by and within the terms of this document.
19. **Exercise Programs.** Exercise programs for treatment of any condition, except for *physician* supervised cardiac rehabilitation, occupational, or physical therapy, if covered by this *Plan*.
20. **Experimental/Investigational.** Care and treatment that is *experimental/investigational*. This exclusion shall not apply if the charge is for routine patient care for costs *incurred* by a *qualified individual* who is a *participant* in an *approved clinical trial*. Charges will be covered only to the extent specifically set forth in this plan document.
21. **Foot Care.** Services for routine, palliative, or *cosmetic* foot care. Examples include flat foot conditions, supportive devices for the foot (orthotics), treatment of subluxation of the foot, care of corns, bunions (except capsular or bone *surgery*), callouses, toe nails, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet. This exclusion does not apply to *medically necessary* foot care services.
22. **Foreign Travel.** Expenses for planned and/or routine services received or supplies purchased outside the United States, including those rendered on a cruise ship, are excluded under this *Plan*. Services in the case of a *medical emergency* or provided through the Global Core Program are a *covered charge*.
23. **Gene Therapy.** Therapy that seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use, other than as provided through Archimedes.
24. **Government Coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid, a Veteran's Administration facility, or when otherwise prohibited by applicable law. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military service-related *illness* or *injury*, benefits are not covered by this *Plan*. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military service-related *illness* or *injury*, benefits are covered by the *Plan* subject to all other applicable *Plan* provisions and as long as the charges are within this *Plan's maximum allowable charge*.
25. **Growth Hormones.** Growth hormones are covered through the Prescription Drug Benefits program. Please refer to the section entitled **Prescription Drug Benefits**.
26. **Hair Loss.** Care and 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 as shown in the applicable Schedule of Medical Benefits. This exclusion does not apply to hair loss services attributed to a covered medical condition.
27. **Hearing Aids.** Charges for services or supplies in connection with hearing aids and exams for their fitting.
28. **Hearing Exam.** Charges for a routine hearing exam, except as may be covered under applicable federal law.
29. **Hospice Care.** Services for pastoral or spiritual counseling; services performed by a family member or volunteer workers, homemaker, or housekeeping services; food services (such as Meals on Wheels); legal and financial counseling services; and services or supplies not included in the *hospice care plan* or not specifically set forth as a hospice benefit.
30. **Hospital Employees.** Professional services billed by a *physician* or nurse who is an *employee* of a *hospital* or *skilled nursing facility* and paid by the *hospital* or facility for the service.
31. **Hospital Services.** *Hospital* services when hospitalization is primarily for *diagnostic testing*/studies or physical therapy when such procedures could have been done adequately and safely on an *outpatient* basis.

32. **Illegal Acts.** Any charge for care, supplies, treatment, and/or services for any *injury* or *illness* which is *incurred* while taking part, or attempting to take part in, an illegal activity (felonies only). It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act.
33. **Immediate Family Member.** Any charge for care, supplies, treatment, and/or services that are rendered by a provider who is related to the *plan participant* by blood or marriage or who ordinarily dwells in the *plan participant's* household.
34. **Immunizations.** Immunizations and vaccinations for the purpose of travel outside of the United States.
35. **Impotence.** Care, treatment, services, supplies, or medication in connection with treatment for impotence.
36. **Infertility.** Care, supplies, services, and treatment for *infertility*, including, but not limited to, artificial insemination, in vitro fertilization, or any assisted reproductive technology (ART) procedure, except for *diagnostic services* rendered for *infertility* evaluation.
37. **Long Term Care.**
38. **Maternity.** Charges for services related to a scheduled home birth. Charges for services related to surrogate *pregnancy*.
39. **Medicare.** Any charge for benefits that are provided, or which would have been provided had the *plan participant* enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (*Medicare*), including any amendments thereto, or under any federal law or regulation, except as provided in the sections entitled **Coordination of Benefits** and **Medicare**.
40. **Milieu Therapy.** A treatment program based on manipulation of the *plan participant's* environment for their benefit.
41. **Negligence.** Care and treatment of an *injury* or *illness* that results from activity where the *plan participant* is found by a court of competent jurisdiction and/or a jury of their peers to have been negligent in their actions, as negligence is defined by the jurisdiction where the activity occurred.
42. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
43. **No Legal Obligation.** Any charge for care, supplies, treatment, and/or services that are provided to a *plan participant* for which the provider of a service customarily makes no direct charge, for which the *plan participant* is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including, but not limited to, fees, care, supplies, or services for which a person, company, or any other entity except the *plan participant* or this benefit *Plan*, may be liable for necessitating the fees, care, supplies, or services.
44. **No Physician Recommendation.** Care, treatment, services, or supplies not recommended and approved by a *physician*. Treatment, services, or supplies when the *plan participant* is not under the regular care of a *physician*. Regular care means ongoing medical supervision or treatment which is appropriate care for the *injury* or *illness*.
45. **No Signs or Symptoms.** Charges for treatment, or services in the absence of signs or symptoms of a specific *injury*, *illness*, or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered herein or required by applicable federal law.
46. **Non-Compliance.** Any additional *inpatient* charges in connection with treatments or medications which were directly caused by, and attributed to, the patient's non-compliance with or discharge from an *inpatient hospital* or *skilled nursing facility* against medical advice. This exclusion does not apply to any subsequent emergency room visits or *outpatient* services.
47. **Non-Emergency Hospital Admissions.** Care and treatment billed by a *hospital* for *medical non-emergency care* admissions on a Friday or a Saturday. This does not apply if *surgery* is performed within twenty-four (24) hours of admission.
48. **Non-Medical Expenses.** Expenses including, but not limited to, those for preparing medical reports or itemized bills, completion of claim forms or medical records unless otherwise required by law, calling a patient to provide their test results, sales tax, shipping and handling, services for telephone consultations (i.e. audio only), expenses for failure to keep a scheduled visit or appointment, *physician* or *hospital* stand-by services, holiday or overtime rates, membership or access fees, educational brochures, or reports prepared in connection with litigation.

49. **Non-Prescription Medication.** Drugs and supplies not requiring a prescription order (unless required under applicable federal law), including, but not limited to, aspirin, antacid, benzyl peroxide preparations, cosmetics, medicated soaps, food supplements, syringes, bandages, or Rogaine hair preparations, special foods or diets, vitamins, minerals, dietary and nutritional supplements, *experimental* drugs, including those labeled "Caution: Federal law prohibits dispensing without prescription," and prescription medications related to health care services which are not covered under this *Plan*.
50. **Not Actually Rendered.** Any charge for care, supplies, treatment, and/or services that are not actually rendered.
51. **Not Medically Necessary.** Any charge for care, supplies, treatment, and/or services that are not *medically necessary*, unless specifically stated as covered herein.
52. **Occupational or Workers' Compensation.** Charges for care, supplies, treatment, and/or services for any condition, *illness*, *injury*, or complication thereof arising out of or in the course of employment (including self-employment), or an activity for wage or profit. If you are covered as a *dependent* under this *Plan* and you are self-employed or employed by an *employer* that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers' compensation insurance will cover your costs, but if you do not have such coverage, fail to file, or receive a denial for failure to file timely, you may end up with no coverage at all.
53. **Orthotics.** Charges in connection with non-custom molded foot orthotics.
54. **Other than Attending Physician.** Any charge for care, supplies, treatment, and/or services by a *provider* who did not render an actual service to the *participant*. *Covered charges* are limited to those certified by a *physician* who is attending the *plan participant* as required for the treatment of *injury* or *disease* and performed by an appropriate provider. This exclusion does not apply to interdisciplinary team conferences to coordinate patient care.
55. **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-medical grade stockings/items (except as specified herein), non-*prescription drugs* and medicines, first-aid supplies, seat risers, wheelchair lifts, and non-hospital adjustable beds.
56. **Personal Injury Insurance.** Expenses in connection with an automobile *accident* for which benefits payable hereunder are, or would be otherwise covered by, mandatory *no-fault automobile insurance* or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the *plan participant* actually had such mandatory coverage. This exclusion does not apply if the *injured* person is a passenger in a non-family-owned vehicle or a pedestrian.
57. **Prescription Drugs.** Prescription drugs charges covered under the Prescription Drug Benefits, other than those covered in a *physician's* office or *inpatient* admission.
58. **Prior to Effective Date or After Termination Date.** Services, supplies, or accommodations provided prior to the *plan participant's* effective date or after the termination of coverage. In the event coverage is terminated during a *hospital* admission, the *Plan* will only consider *covered charges* as those *incurred* before coverage was terminated, unless extension of benefits applies.
59. **Private Duty Nursing.** Charges in connection with care, treatment, or services of a private duty nurse, except as included as a part of another covered service(s), as stated herein.
60. **Prohibited by Law.** Any charge for care, supplies, treatment, and/or services to the extent that payment under this *Plan* is prohibited by law.
61. **Repair of Purchased Equipment.** Maintenance and repairs needed due to misuse or abuse are not covered.
62. **School**. Services performed in a school setting. This exclusion also applies to services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school.
63. **Smoking/Vaping Cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under applicable federal law. Thereafter, the *Plan* will cover cessation services based on applicable benefit level. Refer to the **Prescription Drug Benefits** section for details on coverage of certain tobacco cessation medications.
64. **Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.

65. **Subrogation, Reimbursement, and/or Third-Party Responsibility.** Any charges for care, supplies, treatment, and/or services of an *injury* or *illness* not payable by virtue of the *Plan's* subrogation, reimbursement, and/or third-party responsibility provisions. Refer to the **Reimbursement, Subrogation, and Recovery Provisions** section.
66. **Transplants.** Services and supplies that are *incurred* for care and treatment due to a bone marrow, organ, or tissue transplant are subject to the exclusions stated in the **Transplant Program** section.
67. **Travel or Accommodations.** Charges for travel accommodations, whether or not recommended by a *physician*, except for ambulance charges defined as a *covered charge* or travel required for an approved organ or tissue transplant. Refer to the **Transplant Program** section for details.

    Any of the following or similar items associated with travel:

    a. entertainment items such as alcohol, cigarettes, toys, books, movies, theater tickets, theme park tickets, flowers, greeting cards, stationary, stamps, postage, gifts, internet service, tips, coupons, vouchers, or travel tickets, frequent flyer miles
    b. convenience items such as toiletries, paper products, maid service, laundry/dry cleaning, kennel fees, babysitter/childcare, valet parking, faxing, cell phones, phone calls, newspapers
    c. mortgage, rent, security deposit, furniture, utility bills, appliances, utensils
    d. vacation/apartment rentals (such as Airbnb-type lodging services)
    e. vehicle maintenance, automobile mileage, taxi fares, parking, moving trucks/vehicles, mileage within the medical transplant facility city
    f. cash advances/lost wages
    g. rental cars, buses, taxis, or shuttle service, except as specifically approved by the *Claims Administrator*
    h. meals
    i. prepayments or deposits
    j. taxes
    k. travel costs for donor companion/caregiver
    l. return visits for a transplant donor for a treatment of an *illness* found during the evaluation
68. **Vision Care Exclusions.** Expenses for the following:
    a. routine vision examinations
    b. surgical correction of refractive errors and refractive keratoplasty procedures, including, but not limited to, Radial Keratotomy (RK), Automated Lamellar Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK)
    c. purchase, fitting, and repair of eyeglasses or lenses and associated supplies (except as specified herein)
    d. orthokeratology lenses for reshaping the cornea of the eye to improve vision
    e. specialty lenses such as polarized lenses, transition lenses, coatings, tints, or add-ons
    f. clear lens extraction intraocular lens implant for the correction of refractive error
    g. intraocular lenses used to correct presbyopia and astigmatism
69. **War.** Any loss that is due to a declared or undeclared act of war.
70. **Weight Loss.** Weight loss or dietary control programs.

SECTION VII—TRANSPLANT PROGRAM

A. Transplant Program

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

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

Transplant-related services are services and supplies up to one (1) year following the transplant, which are related to transplantation when recommended by a *physician*, provided at or arranged by a transplant *hospital*, and determined to be *medically necessary*. Such services and supplies include, but are not limited to, *hospital* charges, *physician* charges, organ acquisition charges, tissue typing donor search charges, and ancillary services.

B. Program Benefits

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

Refer to the travel provisions in the **Medical Benefits** section.

C. Requirements

Transplant benefits under the *Plan* are only available when a *plan participant* fully utilizes a transplant network, *network Blue Distinction Center (BDC)/BDC+*, or *network* provider (when a *BDC* or *BDC+* is not available) and meets all of the following requirements:

1. *Pre-certification* **must** be obtained as outlined in the **Health Care Management Program** section.
2. All transplant services must be rendered at a *BDC* or *BDC+*.

   Certain transplant procedures are not available at a *Blue Distinction Center (BDC)/BDC+* designation. In these instances, the *Plan* provides coverage for the procedure and reimbursement of travel expenses to the closest available *network* location that performs the procedure. Cornea transplants are not required to be performed in a *Blue Distinction Center (BDC)/BDC+*.

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

D. Transplant Exclusions

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

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

6. services for a condition that is not directly related, or a direct result, of the transplant

   All other covered services will fall to the applicable benefit as billed and will be subject to all other *Plan* provisions.

SECTION VIII—HEALTH CARE MANAGEMENT PROGRAM

A. Introduction

The health care management program consists of several components to assist *plan participants* in staying well: providing optimal management of chronic conditions, provisions of support, and service coordination during times of acute or new onset of a medical condition.

The scope of the health care management program consists of the following components (each of which will be further discussed in this section):

1. utilization review
2. concurrent review and discharge planning
3. case management
4. health management

B. Utilization Review

The utilization review program is designed to help ensure all *plan participants* receive *medically necessary* and appropriate health care while avoiding unnecessary expenses.

The purpose of the program is to determine what services are *medically necessary* and eligible for payment by the *Plan*. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending *physician* or other health care provider.

If a particular course of treatment or medical service is not *pre-certified*, it means that either the *Plan* will not pay for the charges, or the *Plan* will not consider that course of treatment as *medically necessary* and appropriate for the maximum reimbursement under the *Plan*. The patient is urged to review why there is a discrepancy between what was requested and what was certified before *incurring* charges.

Your *employer* has contracted with the *Medical Management Administrator* in order to assist you in determining whether or not proposed services are appropriate for reimbursement under the *Plan*. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility.

Elements of the Utilization Review Program

The program consists of:

1. **Pre-Certification.** Review of the *medical necessity* for non-emergency services before services are provided.
2. **Retrospective Review.** Review of the *medical necessity* of the health care services provided on an *emergency* basis, after they have been provided.
3. **Concurrent Review.** Ongoing assessment of the health care as it is being provided, especially, but not limited to, *inpatient* confinement in a *hospital* or covered facility (based on the admitting diagnosis and the listed services requested by the attending *physician*).
4. **Discharge Planning.** Certification of services and planning for discharge from a facility or cessation of medical treatment.

Pre-Certification

The provider, patient, or family member must call the *Medical Management Administrator* to receive certification of certain health care management services. This call must be made at least forty-eight (48) hours in advance of services being rendered or within forty-eight (48) hours after an *emergency*.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the out-of-pocket limit.

The following services must be *pre-certified* before the services are provided, or reimbursement from the *Plan* may be reduced:

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)
    a. surgical and non-surgical (excluding routine vaginal or cesarean deliveries)

b. long term acute care facility (LTAC), not *custodial care*

c. *skilled nursing facility*/rehabilitation facility

d. *inpatient mental health*/*substance use disorder* treatment (includes *residential treatment facility* services)

The attending *physician* does not have to obtain *pre-certification* from the *Plan* for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

2. inpatient and outpatient surgery

   Pre-certification is **not** required for the following *surgical procedures*:

   a. office *surgeries*
   b. all colonoscopies and sigmoidoscopies (screening and diagnostic)
   c. elective sterilization procedures

   Bariatric surgery, and certain joint and spinal surgeries, performed through Carrum Health would need be *pre-certified* through Carrum Health. Refer to the **Quick Reference Information Chart** subsection for contact information.

3. transplant (other than cornea), including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy
4. *adoptive cell therapy*
5. *durable medical equipment (DME)* in excess of $1,500 (purchase/rental price)
6. genetic/genomic testing (excluding amniocentesis)
7. *home health care services* (excluding home infusion services)
   a. private-duty nursing in the home setting
8. non-emergent air ambulance
9. prosthetics
10. *outpatient* advanced imaging (excluding services rendered in an emergency room setting)
    a. computed tomographic (CT) studies
    b. coronary CT angiography
    c. MRI/MRA
    d. nuclear cardiology
    e. nuclear medicine (including SPECT scans)
    f. PET scans
11. partial hospitalization and intensive *outpatient* program
12. radiation treatments for oncology diagnoses
13. transcranial magnetic stimulation (TMS)
14. oncology diagnoses only- injected, infused, or implanted *prescription drugs* and therapies which are covered under the medical benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an outpatient facility, *physician's* office, or home infusion) which are listed at engage.ameriben.com.

    The following oncology diagnoses services must be *pre-certified* through Archimedes (please refer to www.memberservices@archimedesrx.com):

    a. *gene therapy*
15. injected, infused, or implanted *prescription drugs* and therapies (other than those for oncology diagnoses) which are covered under the medical benefits and not obtained through the **Prescription Drug Benefits** (i.e.

provided in an *outpatient* facility, physician's office, or home infusion) which are listed at **engage.ameriben.com**.

For specialty drugs obtained through the Pharmacy Benefits Manager, please refer to the **Prescription Drug Benefits** section for additional information and requirements for prior authorization. s

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

In order to maximize Plan reimbursements, please read the following provisions carefully.

How to Request Pre-Certification

Before a *plan participant* enters a *medical care facility* on a non-emergency basis or receives other listed medical services, the *Medical Management Administrator* will, in conjunction with the attending *physician*, certify the care as *medically necessary* for *Plan* reimbursement. A non-emergency stay in a *medical care facility* is one that can be scheduled in advance.

The medical management program is set in motion by a telephone call from, or on behalf of, the *plan participant*. Contact the *Medical Management Administrator* **at least forty-eight (48) hours before** services are scheduled to be rendered with the following information:

1. the name of the *plan participant* and relationship to the covered *employee*
2. the name, *employee* identification number, and address of the covered *employee*
3. the name of the *employer*
4. the name and telephone number of the attending *physician*
5. the name of the *medical care facility*
6. the proposed medical services
7. the proposed date(s) of services
8. the proposed length of stay

If there is an *emergency* admission to the *medical care facility*, the patient, patient's family member, *medical care facility*, or attending *physician* must contact the *Medical Management Administrator* within **forty-eight (48) hours** of the first business day after the admission. Refer to the Quick Reference Information Chart for contact information.

The *Medical Management Administrator* will determine the number of days of *medical care facility* confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the *Plan*.**

Warning: Obtaining *pre-certification* of particular services does not guarantee that they will be reimbursed by the *Plan*. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this plan document.

NOTE: If your admission or service is determined to **not** be *medically necessary*, you may pursue an *appeal* by following the provisions described in the **Claims and Appeals** section (First Level Appeal of a Pre-Service Claim subsection) of this document. The *plan participant* and provider will be informed of any denial or non-certification in writing.

Penalty for Failure to Pre-Certify

When the required *pre-certification* procedures are followed, your benefits will be unaffected. However, if you do not follow the *pre-certification* requirements outlined above, **you may be subject to a $300 penalty for any resulting *out-of-network claims***. Penalty will be applied to the facility charge, if applicable. Amounts assessed under this penalty will not go towards satisfaction of your *out-of-pocket limit*.

Appeals of a Denial of Pre-Certification from the Medical Management Administrator

Pre-certification decisions are considered *claims* decisions that are subject to *appeal*. Refer to the **Claims and Appeals** section (Other Pre-Service Claims subsection) for details on how to *appeal* and the timeframes for appealing a *pre-service claim* decision.

C. Concurrent Review and Discharge Planning

<u>How Concurrent Review Works</u>

Concurrent review of a course of treatment and discharge planning from a *medical care facility* are part of the medical management program. The *Medical Management Administrator* will monitor the *plan participant's medical care facility* stay or use of other medical services and coordinate with the attending *physician*, *medical care facilities*, and *plan participant* either the scheduled release or an extension of the *medical care facility* stay or extension or cessation of the use of other medical services.

If the attending *physician* feels that it is *medically necessary* for a *plan participant* to receive additional services or to stay in the *medical care facility* for a greater length of time than has been *pre-certified*, the attending *physician* must request the additional services or days.

<u>How to File a Concurrent Claim for Benefits under this Plan</u>

Refer to the **<u>Claims and Appeals</u>** section (<u>Concurrent Care Claims</u> subsection) for details on how to *appeal* a denial of a concurrent review. No benefits will be paid for any charges related to days of confinement to a *hospital* or other *health care facility* that have not been determined to be *medically necessary* by the *Medical Management Administrator*.

D. Case Management

Case management is designed to help manage the care of patients who have special or extended care *illnesses* or *injuries*. Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a *plan participant's* health needs, using communication and available resources to promote quality, cost-effective outcomes. The primary objective of case management is to identify and coordinate cost-effective medical care, which meets accepted standards of medical practice. Case management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients, and others.

Cases are identified for possible case management involvement based on a request for review or the presence of a number of parameters, such as, but not limited to:

1. admissions that exceed the recommended or approved length of stay
2. utilization of health care services that generates ongoing and/or excessively high costs
3. conditions that are known to require extensive and/or long-term follow-up care and/or treatment

The *Plan* may elect, at its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the *Plan*. The alternative benefits shall be determined on a case-by-case basis, and the *Plan's* determination to provide the benefits in one (1) instance shall not obligate the *Plan* to provide the same or similar alternative benefits for the same or any other *plan participant*, nor shall it be deemed to waive the right of the *Plan* to strictly enforce the provisions of the *Plan*.

The case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The *Plan Administrator*, attending *physician*, patient, and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the *Plan Administrator* will direct the *Plan* to reimburse for *medically necessary* expenses as stated in the treatment plan, even if these expenses normally would not be paid by the *Plan*. Unless specifically provided to the contrary in the *Plan Administrator's* instructions, reimbursement for expenses *incurred* in connection with the treatment plan shall be subject to all *Plan* limits and cost sharing provisions.

Benefits under case management may be provided if the *Medical Management Administrator* determines that the services are *medically necessary*, appropriate, cost-effective, and feasible. All decisions made by case management are based on the individual circumstances of that *plan participant's* case. Each case is reviewed on its own merits, and any benefits provided are under individual consideration.

All case management is a voluntary service. There are no reductions of benefits or penalties assessed if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

E. **Courtesy Reviews**

AmeriBen Medical Management may perform *courtesy reviews*. *Courtesy reviews* are a pre-service assessment of *medical necessity* only and are not a guarantee of benefits. *Courtesy reviews* will be made as soon as possible after the request has been submitted, but no later than thirty (30) days. Completion of a *courtesy review* is not a requirement of the *Plan* and should not be a cause for delay in treatment of *medically necessary* care. Contact AmeriBen Medical Management with any questions. Refer to the **Claims and Appeals** section for timeframes and other information regarding filing *claims*.

F. Health Management Program

Your *employer* has contracted with AmeriBen Medical Management to provide the Health Management Program. The Health Management Program is designed to assist individuals who are suffering from chronic conditions, or who have been identified as at risk for a chronic condition. The Health Management Program assists *plan participants* with managing those conditions by providing *plan participants* with access to education and personal engagement. This service provides programs for patients to gain education on the care and management of chronic *diseases* (such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), high blood pressure, coronary heart *disease*, etc.) and is designed to improve patient knowledge of the *disease* and techniques for self-management and compliance with proper health care procedures required for the patient’s well-being.

How the Health Management Program Works

This program is designed to educate *plan participants* and eligible family members with chronic *diseases* and help *plan participants* better understand and take control of their condition, proactively participate in care and treatment, and reduce the risk of complications. Participation in the program is voluntary and confidential.

Program Benefits:

1. It is a benefit of your health care plan at no extra cost to you.
2. It provides personal contact between you and a specially trained registered nurse (R.N.), who will be your Health Coach.
3. The program supports your *physicians* as well as helping you follow your doctor’s plan of care.

This program does not replace *physician*-patient relationships. It is designed to complement the relationship and reinforce the treatment plan of care established by you and your *physician*. All Protected Health Information (PHI) is highly confidential, will be kept confidential as required by law, and shall not be improperly used or disclosed.

Managing Chronic Conditions

Chronic health management is a proactive approach that addresses chronic *diseases* early in the *disease* cycle to prevent *disease* progression and reduce potential health complications. Multiple strategies are used to improve the health of all *plan participants* diagnosed with specific conditions, not only those who visit the provider’s office. This approach allows *plan participants* to maintain their independence and remain healthy for as long as possible.

AmeriBen’s dedicated team of health management nurses accomplish this by reinforcing proper treatment plans and educating *plan participants* about their conditions. This typically incudes information about:

1. the early signs and symptoms of trouble
2. medications and the proper way to take them
3. following a healthy diet
4. managing and maintaining scheduled doctor visits
5. preventing *hospital* admissions

While the specific list of conditions and programs will vary, the Health Management Program’s main goal is to empower the *plan participant* to take control and remain healthy.

How to Enroll

Your *physician* may refer you to the Health Management Program, or you may refer yourself or a covered *dependent* into the program by calling AmeriBen Medical Management directly at «MMA_Phone» or by visiting **engage.ameriben.com**. *Plan participants* may also be identified through the Predictive Modeling tool. Once you are identified as having a chronic condition, your R.N. health coach will contact you to discuss the next steps of the program.

SECTION IX—PRESCRIPTION DRUG BENEFITS

A. About Your Prescription Benefits

The *prescription drug* benefits are separate from the medical benefits and are administered by AffirmedRx (PBM Vendor). AffirmedRx maintains the prescription drug formulary, manages a *network* of participating *pharmacies*, and facilitates mail service. This program allows you to use your ID card at a nationwide *network* of participating *pharmacies* to purchase your prescriptions. When purchasing *prescription drugs* at retail *pharmacies* or through mail order, using your ID card at participating *pharmacies* provides you with the best economic benefit.

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

Claims for reimbursement of *prescription drugs* are to be submitted to the Pharmacy Benefits Manager at the address listed in the Quick Reference Information Chart.

B. Eligibility

You are eligible for enrollment in the *prescription drug* benefit if you are enrolled in one of the medical coverage options under the *Plan*. Your *dependents* are eligible for enrollment in the **Prescription Drug Benefit** if they are enrolled in Medical Coverage. Refer to the **Eligibility, Effective Date, and Termination Provisions** section of this summary plan description for information on eligibility.

C. Enrollment

You and your eligible *dependents* will be automatically enrolled in the *prescription drug* benefit upon enrollment in medical coverage. Any changes you make to your medical coverage at open enrollment and during the year (refer to the **Eligibility, Effective Date, and Termination Provisions** section of this summary plan description) will also apply to your *prescription drug* benefit coverage.

Your *prescription drug* benefit coverage will become effective on the date your medical coverage becomes effective. Coverage for your eligible *dependents* will become effective on the date their medical coverage becomes effective. Refer to the **Eligibility, Effective Date, and Termination Provisions** section of the summary plan description for information on enrollment.

D. Cost of Coverage

You and the *employer* share in the cost of the plan. Information describing your share of the cost of the plan, which includes your share of the cost of the *prescription drug* benefit, will be available at enrollment.

E. Understanding Your Benefits

Please note:

"Generic" or "brand name" is listed if only that product type is covered.

Treatment recommendations may vary. Please call your doctor or pharmacist if you have questions about your health or medicine.

Prescription Drug Formulary

Your coverage under AffirmedRx is based on a formulary – a list of covered medicines. Your formulary offers a wide selection of clinically sound, cost-effective generic and brand name *prescription drugs*. For more information or to check drug coverage, visit www.affirmedrx.com/purdue or contact AffirmedRx at 1-877-828-1049.

Your Cost for Prescriptions

The amount you pay for your covered medications will generally depend on two (2) factors:

1. Whether your prescription is filled with a generic, a brand-name, or a specialty medication
2. Where your prescription is filled (at a participating retail pharmacy, at an *out-of-network* retail *pharmacy*, through a mail service *pharmacy*, or through a specialty *pharmacy*)

The amount you pay for covered medications may include a *deductible*, *co-payment*, and/or *co-insurance*.

1. A *deductible* is the amount you pay for covered medications under the *Plan* before the *Plan* starts to pay.
2. A *co-payment* is a fixed amount that you pay for a covered medication under the *Plan* after you have paid your *deductible*.
3. *Co-insurance* is the percentage of costs of a covered medication that you pay under the *Plan* after you have paid your *deductible*.

Quantity Limits

For some medications, the *prescription drug* benefit covers a limited quantity within a specific period of time. A coverage review may be available to request additional quantities of these medications. Please note that the *pharmacy* does not automatically initiate a coverage review process for additional quantities. You or your doctor must initiate this process.

For more information on quantity limits, including a list of *prescription drugs* with quantity level limits, visit the AffirmedRx website at **www.affirmedrx.com/purdue**.

Please note: The dosage form is how the product is supplied. For example, tablet, capsule, liquid, syrup or chewable tablet.

F. Out-of-Pocket Maximums

Once your out-of-pocket expenses for covered medications under the plan reaches the levels specified in this summary plan description, the *Plan* will pay for covered medications at 100% for the remainder of the *plan year*. The amount you spend on *deductibles*, *co-payments*, and *co-insurance* counts toward the *out-of-pocket maximum*.

G. Preventive Drugs

Your doctor must write a *prescription* for *preventive care* services to be covered under the prescription drug benefits, even if they are listed as over-the-counter.

H. Retail Participating Pharmacy

Participating *pharmacies* have contracted with the *Plan* to charge *plan participants* reduced fees for covered *prescription drugs*.

To fill your prescription at a retail participating *pharmacy*, present your written prescription from your *physician* and your ID card to the pharmacist. Alternatively, some physicians send prescriptions to *pharmacies* electronically, in which case you will only need to present your ID card. You will be charged at the point of purchase for applicable *deductible* and/or *co-payment/co-insurance* amounts. If you do not present your ID card, you may have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to AffirmedRx along with the required *claim* form.

I. Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart *disease*, high blood pressure, asthma, etc.). Because of volume buying, Mark Cuban Cost Plus Drug Company and Amazon Pharmacy, the mail order *pharmacy*, may be able to offer *plan participants* significant savings on their prescriptions. For *prescription drugs* you take regularly to treat ongoing conditions, you may fill a ninety (90) day supply through Amazon or Mark Cuban Cost Plus online pharmacies.

J. Out-of-Network Pharmacy

If you use a *pharmacy* that is not covered in the *network*, you must pay the entire cost of the *prescription drug* and then submit a *claim* for reimbursement.

K. Specialty Pharmacy Program

Archimedes is a specialty pharmacy program offered through a partnership with a specialty *pharmacy* experience in handling specialty drugs. The specialty pharmacy program covers some limited drugs, such as specialty injectables, cancer drugs, and certain respiratory therapies used to treat various chronic conditions. Archimedes also provides personalized support, education, a proactive refill process, and free delivery, as well as information about health care needs related to the chronic *disease*. If you are prescribed a specialty drug, you may fill your prescription through Archimedes or the limited distribution drug (LDD) wrap specialty network.

To start using Archimedes, call toll free at 1-888-318-0445 or visit Memberservices@archimedesrx.com.

L. Prior Authorization

Prescriptions for certain medications or circumstances require clinical approval before they can be filled, even with a valid prescription. Prescriptions may be limited to quantity, frequency, dosage, or may have age restrictions. The authorization process may be initiated by the *plan participant*, the local *pharmacy*, or the *physician* by calling AffirmedRx at 1-877-828-1049.

Utilization Management Programs

To promote safety along with appropriate and cost-effective use of *prescription drugs*, the Prescription Drug Benefit includes several utilization management programs.

Prior Authorization/Pre-Certification

Prescriptions for certain medications require a *pre-certification* to ensure the medication is cost-effective and clinically appropriate. The review uses both formulary and clinical guidelines and other criteria to determine if the plan will pay for certain medications.

The following situations may require *pre-certification* for your prescription:

1. Your doctor prescribes a medication not covered by the formulary
2. The medication prescribed is subject to age limits
3. The medication is only covered for certain conditions

In most cases, *pre-certification* can be started by phone by your pharmacist, in collaboration with your *physician*.

For more information on *pre-certification*, including a list of drugs that require *pre-certification*, visit the AffirmedRx website at **www.affirmedrx.com/purdue** and use the Formulary Drug Search tool.

M. Step Therapy Program

The *prescription drug* benefit includes a step therapy program for drugs used to treat certain medication conditions. The step therapy program is designed to find the most appropriate medication therapy and reduce prescription costs. Medications are grouped into two (2) categories:

1. **First-line (or Step 1) medications:** these are the medications recommended for you to take first —usually generics, which have been proven safe and effective. You pay the lowest *co-payment* for these.
2. **Second-line (or Step 2) medications: t**hese are brand-name medications. They are recommended for you only if a first-line medication does not work. You may pay more for brand-name medications.

For more information on step therapy, including a list of drugs that require step therapy, visit the AffirmedRx website at **www.affirmedrx.com/purdue** and use the Formulary Drug Search tool.

N. Medicare Part D Prescription Drug Plans for Medicare Eligible Participants

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

O. Covered Prescription Drug Charges

1. **Compounded Prescription Drugs.** All compounded *prescription drugs* containing at least one (1) prescription ingredient in a therapeutic quantity.
2. **Diabetic.** Insulin, continuous blood glucose monitor and supplies, glucometer, and other diabetic supplies when prescribed by a *physician.*

   Visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of diabetic supplies related *preventive care* benefits.
3. **Growth Hormones.**
4. **Injectable Drugs.** Injectable drugs or any prescription directing administration by injection.
5. **Prescribed by Physician.** All drugs prescribed by a *physician* that require a prescription either by federal or state law.

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

   This provision includes, but is not limited to, the following categories of drugs (In order for these medications to be covered at 100%, a prescription is required from your *physician*, including over-the-counter drugs.):
   a. **Breast Cancer Risk-Reducing Medications.** Medications such as tamoxifen or raloxifene for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
   b. **Contraceptives**.
      i. Oral contraceptives, regardless of the reason prescribed.
      ii. Contraceptive devices.
   c. **Immunizations.** Certain vaccinations are available without cost sharing including vaccines for influenza, pneumonia, tetanus, hepatitis, shingles, measles, mumps, HPV (human papillomavirus), pertussis, varicella, and meningitis. If the *pharmacy* is *non-network*, those vaccinations will be reimbursable under the medical benefits at 100%.
   d. **Tobacco/Vaping Cessation Products**. Such as nicotine gum, smoking deterrent patches, or generic tobacco cessation medications. These drugs are payable without cost sharing up to a one hundred sixty-eight (168) day supply, twenty-four (24)-week course of treatment per *calendar year*, which applies to all products. Thereafter, the applicable *co-payment/co-insurance* applies.
   e. **Preparation 'Prep' Products for a Colon Cancer Screening Test.** The *Plan* covers the over-the-counter or prescription strength products prescribed as preparation for a payable preventive colon cancer screening test, such as a colonoscopy.

   Please refer to the following website for information on the types of payable preventive medications: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or

http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.

P. Limits to This Benefit

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

1. refills only up to the number of times specified by a *physician*
2. refills up to one (1) year from the date of order by a *physician*
3. a thirty (30) day supply or ninety (90) day supply for retail prescriptions
4. a ninety (90) day supply for mail-order prescriptions

Q. Dispense As Written (DAW) Program

The Plan requires that retail pharmacies dispense generic drugs when available. Should a plan participant choose a formulary brand or non-preferred formulary drug rather than the generic equivalent, the plan participant will be responsible for the cost difference between the generic and formulary brand or non-preferred formulary in addition to the formulary brand or non-preferred formulary drug co-payment, even if a DAW (Dispense As Written) is written by the prescribing physician. The plan participant's share of this prescription drug cost difference does not apply toward the Plan's out-of-pocket limit.

Generics Preferred Program (Automatic Generic Substitution)

Generic medications may lower your out-of-pocket costs. With a generic medication, you get the same treatment that you get with its brand-name counterpart, but with a lower *co-payment*. FDA-approved generic equivalent medications contain the same active ingredients and are subject to the same standards established by the FDA as their brand-name counterparts. To help manage the cost of *prescription drug* benefits, the *prescription drug* benefit includes an automatic generic substitution feature.

How does the "generics preferred program" work? When your doctor prescribes a brand-name medication and a generic substitute is available, you will automatically receive the generic unless:

1. Your doctor writes Dispense As Written ("DAW") on the prescription
2. You request the brand-name medication at the time you fill your prescription

If a generic version is available, but you or your provider requests the brand-name medication, you will pay the brand-name benefit level in addition to the full difference in cost between the brand-name medication and the generic equivalent. This difference in cost is referred to as the ancillary fee. The ancillary fee is in addition to the *co-payment*, so the cost could exceed the *co-payment* maximum. This amount is not counted toward your *out-of-pocket maximum*.

R. Prescription Drug Plan Exclusions

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

1. **Abortion.** Drugs that induce abortion such as Mifepristone (RU-486).
2. **Administration.** Any charge for the administration of a covered *prescription drug*.
3. **Appetite Suppressants/Dietary Supplements.** A charge for appetite suppressants, dietary supplements, or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
4. **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
5. **COVID-19 Home Tests.** At-home/over-the-counter tests for COVID-19. Refer to the Medical Benefits section of this summary plan description for coverage information.

6. **Cosmetic.** Medications that are cosmetic in nature (i.e., facial wrinkle, pigmenting, de-pigmenting, hair growth, eyelash growth, hair removal, nail, and scar treatment products, etc.).
7. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
8. **Drugs Used for Cosmetic Purposes.** Charges for drugs used for *cosmetic* purposes, such as anabolic steroids, Retin A, or medications for hair growth or removal.
9. **Experimental/Investigational.** *Experimental/investigational* drugs and medicines, even though a charge is made to the *plan participant*. A drug or medicine labeled: "Caution: Federal law prohibits dispensing without prescription."
10. **FDA.** Any drug not approved by the Food and Drug Administration.
11. **Impotence.** A charge for impotence medication.
12. **Infertility.** A charge for *infertility* medication.
13. **Inpatient Medication.** A drug or medicine that is to be taken by the *plan participant*, in whole or in part, while *hospital* confined. This includes being confined in any *institution* that has a facility for the dispensing of drugs and medicines on its premises.
14. **Medical Exclusions.** A charge excluded under the Medical Plan Exclusions subsection, unless specifically covered in this **Prescription Drug Benefits** section.
15. **No Charge.** A charge for *prescription drugs* which may be properly received without charge under local, state, or federal programs.
16. **Non-Legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
17. **Over-the-Counter Drugs.** Charges for over-the-counter drugs or medicines, regardless of whether purchased on the advice of a *physician*, unless required by law. A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
18. **Refills.** Any refill that is requested more than one (1) year after the prescription was written or any refill that is more than the number of refills ordered by the *physician*.

This is not intended to be an exhaustive list and is subject to change.

Please note: other rules, limits and exclusions may apply.

S. When Coverage Ends; COBRA Continuation

When Coverage Ends

Your coverage under the *prescription drug* benefit will end when your medical coverage ends. Your eligible *dependent's* coverage under the *prescription drug* benefit will end when their medical coverage ends. Refer to the **Eligibility, Effective Date, and Termination Provisions** section of the summary plan description for information on termination dates.

Under some circumstances, you or your eligible *dependents* may continue coverage through COBRA continuation coverage. Refer to the **Continuation Coverage Rights under COBRA** section of the summary plan description for information on COBRA coverage.

Coverage During Leave of Absence

If you are on an approved leave of absence and are receiving pay directly from the *employer*, your elections and salary reduction contributions will continue in accordance with the elections you made.

If you are on an approved leave where you are not receiving pay directly from the *employer*, your *employer* will continue your coverage for the duration of time required under the Family and Medical Leave Act (FMLA) or for such longer period as provided for in leave of absence policies in effect at the time of your unpaid leave. You may be required to pay your share of premium during this time.

T. Claims and Appeals

Prescription drug claims and *appeals* are managed by the Pharmacy Benefits Manager. Please contact the Pharmacy Benefits Manager as listed in the Quick Reference Information Chart for additional information.

Claims for Benefits: How to File an Initial Claim

If you need reimbursement for a prescription drug claim, you must file a claim for benefits with the Claims Administrator. You must complete and submit the Direct Member Reimbursement Claim Form ("DMR Form"), along with any other information required by the DMR Form. You can obtain the DMR Form at **www.affirmedrx.com/purdue**.

Mail the completed DMR Form (along with any other information required by the DMR form) to the following e-mail address: **help@affirmedRx.com**.

Claims for Benefits: How an Initial Claim for Benefits is Processed

Your claim for pharmacy benefits will be processed upon receipt by the *Claims Administrator*, in accordance with the procedures fully set forth in the medical summary plan description. The *Claims Administrator* will decide *pharmacy claims* for benefits.

Claims for Benefits and Prior Authorization Denials: How to File an Appeal

If your initial claim for benefits or prior authorization request is denied in whole or in part, you may file an appeal with the *Claims Administrator*.

You may mail your appeal to the following:

PA Logic: AffirmedRx
1510 Pumphery Ave.
Auburn, AL 36832

Claims for Benefits: How an Appeal is Processed

Your *appeal* will be conducted without regard to your initial determination by someone other than the party who decided your initial *claim*. No deference will be afforded to the initial determination. You will have the opportunity to submit written comments, documents or other information in support of your *appeal*. You have the right to request copies, free of charge, of all documents, records or other information relevant to your *claim*. The *Claims Administrator*, on behalf of the *Plan*, will provide you with any new or additional evidence or rationale considered in connection with your *claim* sufficiently in advance of the appeals determination date to give you a reasonable opportunity to respond.

If your *claim* involves a medical judgment question, the *Claims Administrator* will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on *appeal*. Upon request, the *Claims Administrator* will provide you with the identification of any medical expert whose advice was obtained on behalf of the *Plan* in connection with your *appeal*.

In the case of an *urgent care claim*, you may request an expedited *appeal* of an *adverse benefit determination* either orally or in writing, and all necessary information, including the *Plan's benefit determination* on *appeal*, will be transmitted by telephone, fax, or other available expeditious method.

The *Claims Administrator* will make a final decision on appeal within the time periods set forth in the medical summary plan description.

Claims for Benefits: Notice of Determination

If your *claim* or *appeal* is in part or wholly denied, you will receive notice of an *adverse benefit determination* in accordance with the requirements fully set forth in the medical summary plan description.

You may have the right to request an independent review with respect to any *claim* that involves medical judgment or a rescission of coverage. Your *external review* will be conducted by an *independent review organization* (*IRO*) not affiliated with the *Plan*. This *independent review organization* may overturn the *Plan's* decision, and the *independent review organization's* decision is binding on the *Plan*. Your *appeal* denial notice will include more information about your right to file a request for an *external review* and contact information.

You or your *authorized representative* may request *external review* by submitting supporting documentation, such as clinical records or medical history information. You must file your request for *external review* within four (4) months

of receiving your final internal appeal determination. Filing a request for *external review* will not affect your ability to bring a legal claim in court. When filing a request for *external review,* you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the *external review*.

You may mail your request for *external review* to the following:

PA Logic: AffirmedRx
1510 Pumphery Ave.
Auburn, AL 36832

The *independent review organization* will provide you and the *Claims Administrator* (on behalf of the *Plan*) with written notice of its final *external review* decision within forty-five (45) days after it receives the request. You may also request an expedited *external review* and it will be conducted as quickly as possible.

Deadline to Bring Legal Action

You may not bring a lawsuit to recover benefits under this *Plan* until you have exhausted the administrative process described in this section. Please refer to the medical summary plan description for more information on the deadline to bring legal action.

<u>SECTION X—CLAIMS AND APPEALS</u>

Please refer to the *Plan's* wrap document(s).

SECTION XI—COORDINATION OF BENEFITS

A. Coordination of the Benefit Plans

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

Non-Duplication/Maintenance of Benefits

The plan that pays first according to the rules will pay as if there were no *other plan* involved. The secondary will pay up to its own plan formula minus whatever the primary plan paid.

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

Primary Plan	$800
Secondary Plan	$100
Patient Responsibility	$100
Total Amount Paid	$1,000

If the *plan participant* is *Medicare* primary, *claims* are coordinated with the *Plan* according to the *Medicare* allowed amounts. The coordination of these *claims* is standard coordination of benefits. The plan that pays first according to the rules will pay as if there were no *other plan* involved. The secondary and subsequent plans will pay the balance due up to 100% of the total *allowable charges*.

B. Excess Insurance

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

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

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

C. Allowable Charge

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

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

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

D. General Limitations

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

E. Application to Benefit Determinations

The plan that pays first according to the rules in the subsection entitled Benefit Plan Payment Order will pay as if there were no *other plan* involved. The secondary will pay up to its own plan formula minus whatever the primary plan paid.

When there is a conflict in the rules, this *Plan* will never pay more than 50% of *allowable charges* when paying secondary. Benefits will be coordinated as referenced in the Claims Determination Period subsection.

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

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

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

F. Benefit Plan Payment Order

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

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

i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the *child* as a *dependent* will be considered next. The benefit plan of the parent without custody will be considered last.

iii. This rule will be in place of items (i.) and (ii.) immediately above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before *other plans* that cover the child as a *dependent*.

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

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

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

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

3. *Medicare* will pay primary, secondary, or last to the extent stated in federal law. Refer to the *Medicare* publication Your Guide to Who Pays First at **https://www.medicare.gov/publications/02179-Medicare-and-other-health-benefits-your-guide-to-who-pays-first.pdf**. When *Medicare* would be the primary payer if the person had enrolled in *Medicare*, this *Plan* will base its payment upon benefits that would have been paid by *Medicare* under Parts A and B, regardless of whether or not the person was enrolled under any of these parts. The *Plan* reserves the right to coordinate benefits with respect to *Medicare* Part D. The *Plan Administrator* will make this determination based on the information available through Centers for Medicare & Medicaid Services (CMS). If CMS does not provide sufficient information to determine the amount *Medicare* would pay, the *Plan Administrator* will make *reasonable* assumptions based on published *Medicare* fee schedules.
4. If a *plan participant* is under a disability extension from a previous benefit plan, that benefit plan will pay first, and this *Plan* will pay second.
5. When an adult *dependent* is covered by their spouse's plan and is also covered by a parent's plan, the benefits of the benefit plan which has covered the patient for the longest time are determined before those of the *other plan*.
6. When an adult *dependent* is covered by multiple parents' plans, the benefits of the benefit plan of the parent whose birthday falls earlier in the year are determined before those of the benefit plan of the parent whose birthday falls later in that year. Should both/all parents have the same birthday, the benefits of the benefit plan which has covered the patient the longest shall be determined first.
7. The *Plan* will pay primary to Tricare and a state *Children's Health Insurance Program* to the extent required by federal law.

G. Coordination with Government Programs

1. **Medicaid/IHS.** If a *plan participant* is covered by both this *Plan* and Medicaid or Indian Health Services (IHS), this *Plan* pays first and Medicaid or IHS pays second.
2. **Veterans Affairs or Military Medical Facility Services.** If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military-service-related *illness* or *injury*, benefits are not covered by this *Plan*. If a *plan participant* receives services in a U.S.

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

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

H. Claims Determination Period

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

I. Right to Receive or Release Necessary Information

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

J. Facility of Payment

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

K. Right of Recovery

Please refer to the *Plan's* wrap document(s).

L. Exception to Medicaid

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

SECTION XII—MEDICARE

A. Application to Active Employees and Their Spouses

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

B. Applicable to All Other Participants Eligible for Medicare Benefits

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

SECTION XIII—REIMBURSEMENT, SUBROGATION, AND RECOVERY PROVISIONS

These **Reimbursement, Subrogation, and Recovery Provisions** apply when the *Plan* pays benefits as a result of *injuries* or *illnesses* the *plan participant* sustained, and the *plan participant* has a right to a recovery or have received a recovery from any source.

A. Definitions

As used in these **Reimbursement, Subrogation, and Recovery Provisions**, '*plan participant'* includes anyone on whose behalf the *Plan* pays benefits. These **Reimbursement, Subrogation, and Recovery Provisions** apply to all current or former *plan participants* and *Plan* beneficiaries. The provisions also apply to the parents, guardian, or other representative of a *dependent* child who incurs *claims* and is or has been covered by the *Plan*. The *Plan's* rights under these provisions shall also apply as listed in the *Plan's* wrap document(s)..

As used in these **Reimbursement, Subrogation, and Recovery Provisions**, 'recovery' includes, but is not limited to, monies received from any person or party; any person's or party's liability insurance coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers' compensation insurance or fund, premises medical payments coverage, restitution, or "no-fault" or personal *injury* protection insurance and/or automobile medical payments coverage; or any other first- or third-party insurance coverage, whether by lawsuit, settlement, or otherwise. Regardless of how the *plan participant* or the *plan participant's* representative or any agreements allocate or characterize the money the *plan participant* receives as a recovery, it shall be subject to these provisions.

B. Subrogation

Please refer to the *Plan's* wrap document(s).

C. Reimbursement

Please refer to the *Plan's* wrap document(s).

D. Secondary to Other Coverage

The *Plan* shall be secondary in coverage to any medical payments provision, *no-fault automobile insurance* policy, or personal *injury* protection policy regardless of any election made by the *plan participant* to the contrary. The *Plan* shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

E. Assignment

In order to secure the *Plan's* rights under these **Reimbursement, Subrogation, and Recovery Provisions**, The *plan participant* agrees to assign to the *Plan* any benefits or *claims* or rights of recovery the *plan participant* has under any automobile policy or other coverage, to the full extent of the *Plan's* subrogation and reimbursement *claims*. This assignment allows the *Plan* to pursue any *claim* the *plan participant* may have regardless of whether the *plan participant* chooses to pursue the *claim*.

F. Applicability to All Settlements and Judgments

Please refer to the *Plan's* wrap document(s).

G. Constructive Trust

Please refer to the *Plan's* wrap document(s).

H. Lien Rights

Please refer to the *Plan's* wrap document(s).

I. First-Priority Claim

Please refer to the *Plan's* wrap document(s).

J. Cooperation

Please refer to the *Plan's* wrap document(s).

K. Discretion

Please refer to the *Plan's* wrap document(s).

SECTION XIV—CONTINUATION COVERAGE RIGHTS UNDER COBRA

Please refer to the *Plan's* wrap document(s). This *notice* is intended to inform *plan participants* and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This *notice* is intended to reflect the law and does not grant or take away any rights under the law.

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

A. COBRA Continuation Coverage

Please refer to the *Plan's* wrap document(s).

B. Qualified Beneficiary

Please refer to the *Plan's* wrap document(s).

C. Qualifying Event

Please refer to the *Plan's* wrap document(s).

D. Notice of Unavailability of Continuation Coverage

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

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

E. Factors to Consider in Electing COBRA Continuation Coverage

Please refer to the *Plan's* wrap document(s).

F. Procedure for Obtaining COBRA Continuation Coverage

Please refer to the *Plan's* wrap document(s).

G. The Election Period

Please refer to the *Plan's* wrap document(s).

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

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

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

IMPORTANT:

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

<u>Notice Procedures</u>

Please refer to the *Plan's* wrap document(s).

I. Waiver Before the End of the Election Period

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

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

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

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

1. Please refer to the *Plan's* wrap document(s).

L. Maximum Coverage Periods for COBRA Continuation Coverage

Please refer to the *Plan's* wrap document(s).

M. Circumstances in Which the Maximum Coverage Period Can be Expanded

Please refer to the *Plan's* wrap document(s).

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

Please refer to the *Plan's* wrap document(s).

O. Payment for COBRA Continuation Coverage

Please refer to the *Plan's* wrap document(s).

P. Timely Payment for COBRA Continuation Coverage

Please refer to the *Plan's* wrap document(s). Notwithstanding certain information about payments, the *Plan* does not require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than forty-five (45) days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary. Payment is considered made on the date on which it is postmarked to the *Plan*.

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

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

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

R. If You Have Questions

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

S. Keep Your Plan Administrator Informed of Address Changes

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

T. If You Wish to Appeal

In an effort to provide all qualified beneficiaries with a fair and thorough review process for COBRA-related *claims*, all determinations regarding COBRA eligibility and coverage will be made in accordance with the **Continuation Coverage Rights Under COBRA** section of this governing plan document. Accordingly, if a qualified beneficiary wishes to *appeal* a COBRA eligibility or coverage determination made by the *Plan*, such *claims* must be submitted consistent with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. The *Plan* will respond to all complete *appeals* in accordance with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. A qualified beneficiary who files an *appeal* with the *Plan* must exhaust the administrative remedies afforded by the *Plan* prior to pursuing civil action in federal court under COBRA.

SECTION XV—FUNDING THE PLAN AND PAYMENT OF BENEFITS

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

A. For Employee and Dependent Coverage

Funding is derived from the funds of the *employer* and contributions made by the covered *employees*.

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

Benefits are paid directly from the *Plan* through the *Third Party Administrator*.

Payment for Coverage

The specific amount you must pay for coverage is announced each *plan year*. You pay your contributions for medical coverage on a **before-tax** basis. This means that your payments for these coverages come from your pay before federal, and in most cases, state taxes are withheld. That way, you should pay less in taxes.

The amount and frequency of that contribution is determined by Purdue University (within permissible government guidelines) and announced on an annual basis.

B. Clerical Error

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

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

SECTION XVI—CERTAIN PLAN PARTICIPANTS' RIGHTS UNDER ERISA

A. Introduction

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

1. examine, without charge, at the *Plan Administrator's* office, all plan documents and copies of all documents governing the *Plan*, including a copy of the latest annual report (form 5500 series) filed by the *Plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration
2. obtain copies of all plan documents and other *Plan* information upon written request to the *Plan Administrator*

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

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

B. Enforce Your Rights

If a *plan participant's claim* for a benefit is denied or ignored, in whole or in part, the *plan participant* has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to *appeal* any denial, all within certain time schedules.

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

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

C. Prudent Actions by Plan Fiduciaries

Please refer to the *Plan's* wrap document(s).

D. Assistance with Your Questions

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

SECTION XVII—FEDERAL NOTICES

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

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

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

If a *dependent* becomes eligible to enroll under this provision and the *employee* is not then enrolled, the *employee* must enroll in order for the *dependent* to enroll.

B. Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA generally prohibits discrimination in group premiums based on *genetic information* and the use of *genetic information* as a basis for determining eligibility or setting premiums, and places limitations on genetic testing and the collection of *genetic information* in group health plan coverage. GINA provides clarification with respect to the treatment of *genetic information* under privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

C. Mental Health Parity and Addiction Equity Act of 2008

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and *mental health* or *substance use disorder* benefits, such plan or coverage shall ensure all of the following:

1. The financial requirements applicable to such *mental health* or *substance use disorder* benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to *mental health* or *substance use disorder* benefits (if these benefits are covered by the group health *Plan* or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such *mental health* or *substance use disorder* benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to *mental health* or *substance use disorder* benefits (if these benefits are covered by the group health *Plan* or health insurance coverage offered in connection with such a plan).

Regardless of any limitations on benefits for *mental disorders/substance use disorder* treatment otherwise specified in the *Plan*, any aggregate lifetime limit, annual limit, financial requirement, *non-network* exclusion, or treatment limitation on *mental disorders/substance use disorder* benefits imposed by the *Plan* shall comply with federal parity requirements, if applicable. Please also refer to the *Plan's* wrap document(s).

D. Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

Please refer to the *Plan's* wrap document(s).

E. Non-Discrimination Policy

This *Plan* will not discriminate against any *plan participant* based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This *Plan* will not establish rules for eligibility based on health status, medical condition, *claims* experience, receipt of health care, medical history, evidence of insurability, *genetic information*, or disability.

This *Plan* intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986. If the *Plan Administrator* determines before or during any *plan year* that this *Plan* may fail to satisfy any non-discrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the *Plan Administrator* shall take such action as the *Plan Administrator* deems appropriate, under rules uniformly applicable to similarly situated covered *employees*, to assure compliance with such requirements or limitation.

F. Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Please refer to the *Plan's* wrap document(s).

G. Women's Health and Cancer Rights Act of 1998 (WHCRA)

Please refer to the *Plan's* wrap document(s).

SECTION XVIII—COMPLIANCE WITH HIPAA PRIVACY STANDARDS

A. Compliance with HIPAA Privacy Standards

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.

Certain members of the *employer's* workforce perform services in connection with administration of the *Plan*. In order to perform these services, it is necessary for these *employees* from time to time to have access to Protected Health Information (PHI) (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the *Privacy Standards*), these *employees* are permitted to have such access subject to the following:

1. **General.** The *Plan* shall not disclose Protected Health Information to any member of the *employer's* workforce unless each of the conditions set out in this **Compliance with HIPAA Privacy Standards** section is met. 'Protected Health Information' shall have the same definition as set out in the *Privacy Standards* but please refer to the *Plan's* wrap document(s)..
2. **Permitted Uses and Disclosures.** Please refer to the *Plan's* wrap document(s).
3. **Authorized Employees.** The *Plan* shall disclose Protected Health Information only to members of the *employer's* workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the *Plan*. For purposes of this **Compliance with HIPAA Privacy Standards** section, members of the *employer's* workforce shall refer to all *employees* and other persons under the control of the *employer*.
    a. **Updates Required.** The *employer* shall amend the *Plan* promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
    b. **Use and Disclosure Restricted.** An authorized member of the *employer's* workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform their duties with respect to the *Plan*.
    c. **Resolution of Issues of Noncompliance.** Please refer to the *Plan's* wrap document(s).
4. **Certification of Employer.** The *employer* must provide certification to the *Plan* that it agrees to all of the following:
    a. not use or further disclose the Protected Health Information other than as permitted or required by the plan documents or as required by law
    b. ensure that any agent or subcontractor to whom it provides Protected Health Information received from the *Plan* agrees to the same restrictions and conditions that apply to the *employer* with respect to such information
    c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or *employee* benefit plan of the *employer*
    d. report to the *Plan* any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law
    e. make available Protected Health Information to individual *Plan* members in accordance with Section 164.524 of the *Privacy Standards*
    f. make available Protected Health Information for amendment by individual *Plan* members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the *Privacy Standards*
    g. make available the Protected Health Information required to provide any accounting of disclosures to individual *Plan* members in accordance with Section 164.528 of the *Privacy Standards*
    h. make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the *Plan* available to the Department of Health and Human Services for purposes of determining compliance by the *Plan* with the *Privacy Standards*
    i. if feasible, return or destroy all Protected Health Information received from the *Plan* that the *employer* still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not

feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible

j. ensure the adequate separation between the *Plan* and member of the *employer's* workforce, as required by Section 164.504(f)(2)(iii) of the *Privacy Standards*

Please refer to the *Plan's* wrap document(s) for which members of Purdue University's workforce are designated as authorized to receive Protected Health Information from Purdue University Welfare Benefit Plan (*Plan*).

B. Compliance with HIPAA Electronic Security Standards

Under the *Security Standards* for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the *Security Standards*), the *employer* agrees to the following:

1. The *employer* agrees to implement *reasonable* and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the *employer* creates, maintains, or transmits on behalf of the *Plan*. Electronic Protected Health Information shall have the same definition as set out in the *Security Standards*, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
2. The *employer* shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement *reasonable* and appropriate security measures to protect the Electronic Protected Health Information.
3. The *employer* shall ensure that *reasonable* and appropriate security measures are implemented to comply with the conditions and requirements set forth in **Compliance with HIPAA Privacy Standards**, provisions Authorized Employees and Certification of Employers described above.

SECTION XIX—DEFINED TERMS

The following terms have special meanings and will be italicized when used in this *Plan*. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

Accident

A sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Accidental Injury (Accidental Injuries)

An objectively demonstrable impairment of bodily function caused by trauma from a sudden, unforeseen outside force or object, occurring at an identifiable time and place, and without the *plan participant's* foresight or expectation.

Active Employment

Performance by the *employee* of all the regular duties of their occupation at an established business location of the participating *employer*, or at another location to which they may be required to travel to perform the duties of their employment. An *employee* shall be deemed actively at work if the *employee* is absent from work due to a health factor. In no event will an *employee* be considered actively at work if they have effectively terminated employment.

Adoptive Cell Therapy

A type of immunotherapy in which T cells (a type of immune cell) are given to a patient to help the body fight diseases, such as cancer. In cancer therapy, T cells are usually taken from the patient's own blood or tumor tissue, grown in large numbers in the laboratory, and then given back to the patient to help the immune system fight the cancer. Sometimes, the T cells are changed in the laboratory to make them better able to target the patient's cancer cells and kill them. Types of adoptive cell therapy include, but not limited to, chimeric antigen receptor T-cell (CAR T-cell) therapy and tumor-infiltrating lymphocyte (TIL) therapy. Also called adoptive cell transfer, *cellular adoptive immunotherapy*, and T-cell transfer therapy.

Adverse Benefit Determination

Any of the following: a denial, reduction, rescission, or termination of a *claim* for benefits, or a failure to provide or make payment for such a *claim* (in whole or in part), including determinations of a *claimant's* eligibility, the application of any review under the Health Care Management Program, and determinations that an item or service is *experimental/investigational* or not *medically necessary* or appropriate.

Allowable Charges

The *maximum amount/maximum allowable charge* for any *medically necessary*, eligible item of expense, at least a portion of which is covered under a plan. When some *other plan* pays first in accordance with the Application to Benefit Determinations subsection in the **Coordination of Benefits** section herein, this *Plan's* allowable charges shall in no event exceed the *other plan's* allowable charges. When some *other plan* provides benefits in the form of services rather than cash payments, the *reasonable* cash value of each service rendered, in the amount that would be payable in accordance with the terms of the *Plan*, shall be deemed to be the benefit. Benefits payable under any *other plan* include the benefits that would have been payable had *claim* been duly made therefore.

Alternate Recipient

Any child of a *plan participant* who is recognized under a *medical child support order* as having a right to enrollment under this *Plan* as the *plan participant's* eligible *dependent*. For purposes of the benefits provided under this *Plan*, an alternate recipient shall be treated as an eligible *dependent*.

Ambulatory Surgical Center

A licensed facility that is used mainly for performing *outpatient surgery*, has a staff of *physicians*, has continuous *physician* and nursing care by registered nurses (R.N.s), and does not provide for overnight stays.

Appeal

Please refer to the *Plan's* wrap document(s).

Applied Behavioral Analysis (ABA) Therapy

Applied Behavioral Analysis (ABA) Therapy is an umbrella term describing principles and techniques used in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors. The goal of ABA Therapy is to teach new skills, promote generalization of these skills, and reduce challenging behaviors with systematic reinforcement. ABA Therapy is a combination of services for adaptive behavior treatment, which applies the principles of how people learn and motivations to change behavior. ABA Therapy is designed to address multiple areas of behavior and function such as to increase language and communication, enhance attention and focus, and help with social skills and memory. It generally includes psychosocial interventions, should address factors that may exacerbate behavioral challenges, and is most effective when initiated as soon as feasible after diagnosis is made.

Approved Clinical Trial

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

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

Assignment of Benefits

An arrangement by which a patient may request that their health benefit payments under this *Plan* be made directly to a designated medical provider or facility. By completing an assignment of benefits, the *plan participant* authorizes the *Plan Administrator* to forward payment for a covered procedure directly to the treating medical provider or facility. The *Plan Administrator* expects an assignment of benefits form to be completed, as between the *plan participant* and the provider.

Authorized Representative

An authorized representative is a person or organization a *plan participant* has designated to act on their behalf to submit or *appeal* a *claim*. By authorizing a person or organization to act on your behalf, you are giving them permission to see your Protected Health Information (PHI) and act on all matters related to your

claim and/or *appeal*. If you choose to authorize a person to act on your behalf, all future communications shall be with the designee. Where an *urgent care claim* is involved, a health care professional with knowledge of the medical condition will be permitted to act as a *claimant's* authorized representative without a prior written authorization.

Balance Bill/Surprise Bill

Balance bill refers to the difference between a *non-network provider's* total billed charges and the *allowable charges* off of which the *Plan* will base its reimbursement.

Non-network providers have no obligation to accept the *allowable charge* as payment in full. You are responsible to pay a *non-network provider's* billed charges, even though the *Plan's* reimbursement is based on the *allowable charge*. Any amounts paid for balance bills do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

Benefit Determination

The *Plan's* decision regarding the acceptance or denial of a *claim* for benefits under the *Plan*.

Birthing Center

Any freestanding health facility, place, professional office, or *institution* which is not a *hospital* or in a *hospital*, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.

The birthing center must provide the following:

1. facilities for obstetrical delivery and short-term recovery after delivery
2. care under the full-time supervision of a *physician* and either a registered nurse (R.N.) or a licensed nurse-midwife
3. have a written agreement with a *hospital* in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement

Blue Distinction Center/Blue Distinction Center+

Blue Distinction Center (BDC) Facility: Blue Distinction facilities have met or exceeded national quality standards for care delivery (quality only).

Blue Distinction Center+ (BDC+) Facility: Blue Distinction+ facilities have met or exceeded national quality standards for care delivery AND have demonstrated that they operate more efficiently (quality and cost).

See also *Center of Excellence*.

Brand Name

A trade name medication.

Calendar Year/Benefit Year

January 1st through December 31st of the same year. All *deductibles* and benefit maximums accumulate during the calendar year. Please also refer to the *Plan's* wrap document(s).

Cellular Immunotherapy

A type of therapy that uses substances to stimulate or suppress the immune system to help the body fight cancer, infection, and other diseases. Some types of immunotherapy only target certain cells of the immune system. Others affect the immune system in a general way. Types of immunotherapy include cytokines, vaccines, bacillus Calmette-Guerin (BCG), and some monoclonal antibodies.

Center of Excellence

Medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The *Plan Administrator* shall determine what *network* Centers of Excellence are to be used.

Any *plan participant* in need of an organ transplant may contact the *Medical Management Administrator* as outlined in the Quick Reference Information Chart to initiate the *pre-certification* process resulting in a referral to a Center of Excellence. The *Medical Management Administrator* acts as the primary liaison with the Center of Excellence, patient, and attending *physician* for all transplant admissions taking place at a Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to *plan participant(s)* and updated as requested.

Claim

Any request for a *Plan* benefit, made by a *claimant* or by a representative of a *claimant*, in accordance with a *Plan's* reasonable procedure for filing benefit claims.

Some requests made to the *Plan* are specifically not claims for benefits; for example:

1. an inquiry as to eligibility which does not request benefits
2. a request for prior approval where prior approval is not required by the *Plan*
3. casual inquiries about benefits such as verification of whether a service/item is a covered benefit or the estimated cost for a service

Claimant

Please refer to the *Plan's* wrap document(s).

Claims Administrator

AmeriBen has been hired as the Claims Administrator by the *Plan Administrator* to perform *claims* processing and other specified administrative services in relation to the *Plan*. The Claims Administrator is not an insurer of health benefits under this *Plan*, is not a *fiduciary* of the *Plan*, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*. The Claims Administrator is not responsible for *Plan* financing and does not guarantee the availability of benefits under this *Plan*.

Please refer to the *Plan's* wrap document(s).

Clean Claim

A *claim* that can be processed in accordance with the terms of this summary plan description without obtaining additional information from the service provider or a third party. It is a *claim* which has no defect, impropriety, or special circumstance that delays *timely payment*. A clean *claim* does not include:

1. *claims* under investigation for fraud and abuse
2. *claims* under review for *medical necessity*
3. fees under review for *usual and customariness* and *reasonableness*
4. any other matter that may prevent the expense(s) from being considered a *covered charge*

The claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A *claim* will not be considered to be a clean claim if the *participant* has failed to submit required forms or additional information to the *Plan* as well.

Co-Insurance

The portion of medical expenses (after the *deductible* has been satisfied) for which the *plan participant* and/or *Plan* is responsible.

Concurrent Care Claim

A *Plan* decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

Co-Payment

A specific dollar amount a *plan participant* is required to pay and is typically payable to the health care provider at the time services or supplies are rendered.

Cosmetic

Procedures are considered cosmetic when intended to change a physical appearance that would be considered within normal human anatomic variation. Cosmetic services are often described as those that are primarily intended to preserve or improve appearance.

Cost Sharing Amounts

The dollar amount a *plan participant* is responsible for paying when covered services are received from a provider. Cost sharing amounts include *co-insurance*, *co-payments*, *deductible* amounts, and *out-of-pocket limits*. Providers may bill you directly or request payment of *co-insurance* and/or *co-payments* at the time services are provided. Refer to the applicable Schedules of Benefits for the specific cost sharing amounts that apply to this *Plan*.

Covered Charges

The *maximum allowable charge* for a *medically necessary* service, treatment, or supply meant to improve a condition or *plan participant's* health, which is eligible for coverage in this *Plan*. Covered charges will be determined based upon all other *Plan* provisions. When more than one (1) treatment option is available, and one (1) option is no more effective than another, the covered charge is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the applicable Schedule of Medical Benefits section and as determined elsewhere in this document.

Custodial Care

Care (including *room and board* needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of custodial care include help in walking and getting out of bed, assistance in bathing, dressing, feeding, or supervision over medication which could normally be self-administered.

Deductible

A specified portion of the *covered charges* that must be *incurred* by a *plan participant* before the *Plan* has any liability.

Dentist

A person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent

For information regarding eligibility for dependents, refer to the section entitled **Eligibility, Effective Date, and Termination Provisions** and refer to the *Plan's* wrap document(s).

Developmental Delay

A delay in the appearance of normal developmental milestones achieved during infancy and early childhood, caused by organic, psychological, or environmental factors. Conditions are marked by delayed development or functional limitations especially in learning, language, communication, cognition, behavior, socialization, or mobility.

Diagnosis Related Grouping (DRG)

A method for reimbursing *hospitals* for *inpatient* services. A DRG amount can be higher or lower than the actual billed charge because it is based on an average for that grouping of diagnoses and procedures.

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a *disease* or condition. It must be ordered by a *physician* or other professional provider.

Disease

Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the *Plan* is furnished showing that the individual concerned is covered as an *employee* under any workers' compensation law, occupational disease law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one (1) not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the *Plan*, be regarded as a *sickness*, *illness*, or disease.

Durable Medical Equipment (DME)

Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an *illness* or *injury*, and is appropriate for use in the home.

Emergency

A situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An emergency includes poisoning, shock, and hemorrhage. Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the *Plan*, that an emergency did exist. The *Plan* may, at its own discretion, request satisfactory proof that an emergency or acute condition did exist.

Emergency Services

A medical screening examination [as required under Section 1867 of the Social Security Act (EMTALA)] within the capability of the *hospital* emergency department, including routine ancillary services, to evaluate a *medical emergency* and such further medical examination and treatment as are within the capabilities of the staff and facilities of the *hospital* and required under EMTALA to stabilize the patient.

Employee

A person who is active on the regular payroll of the *employer*, has begun to perform the duties of their job with the *employer*, and is regularly scheduled to work for the *employer* on a full or part-time basis in an employee/*employer* relationship.

Employer

Purdue University

Enrollment Date

The first day of coverage or, if there is a *waiting period*, the first day of the *waiting period*.

Essential Health Benefits

Benefits set forth under the *Patient Protection and Affordable Care Act of 2010* (*PPACA*), including the categories listed in the state of Indiana benchmark plan.

Experimental/Investigational

Services, supplies, care, and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The *Plan Administrator* must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The *Plan Administrator* shall be guided by a reasonable interpretation of *Plan* provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the *claim* and the proposed treatment. The decision of the *Plan Administrator* will be final and binding on the *Plan*. The *Plan Administrator* will be guided by the following principles, any of which comprise a definition of experimental/investigational:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished
2. if the drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval
3. if reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis
4. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis

   'Reliable evidence' shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility, or the protocols of another facility studying substantially the same drug, service, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Benefits covered under the Clinical Trials provision are not considered experimental or investigational.

The *Plan Administrator* has the discretion to determine which drugs, services, supplies, care, and/or treatments are considered experimental, investigational, or unproven.

Explanation of Benefits (EOB)

A document sent to the *plan participant* by the *Third Party Administrator* after a *claim* for reimbursement has been processed. It includes the patient's name, claim number, type of service, provider, date of service, charges submitted for the services, amounts covered by this *Plan*, non-covered services, *cost sharing amounts*, and the amount of the charges that are the *plan participant's* responsibility. This form should be carefully reviewed and kept with other important records.

External Review

Please refer to the *Plan's* wrap document(s).

Family Unit

The covered *employee* and the family members who are covered as *dependents* under the *Plan*.

Fiduciary

Please refer to the *Plan's* wrap document(s).

Final Internal Adverse Benefit Determination

An *adverse benefit determination* that has been upheld by the *Plan* at completion of the *Plan's* internal *appeals* procedures; or an *adverse benefit determination* for which the internal *appeals* procedures have been exhausted under the deemed exhausted rule contained in the *appeals* regulations. For plans with two (2) levels

of *appeals*, the second-level *appeal* results in a final internal *adverse benefit determination* that triggers the right to *external review*.

FMLA Leave

Please refer to the *Plan's* wrap document(s).

Formulary

A list of prescription medications compiled by the third-party payer of safe and effective therapeutic drugs specifically covered by this *Plan*.

Foster Child

A child under the limiting age shown in the **Eligibility, Effective Date, and Termination Provisions** section of this *Plan* for whom a covered *employee* has assumed a legal obligation in connection with the child's placement with a state, county, or private foster care agency.

A covered foster child is not a child temporarily living in the covered *employee's* home; one placed in the covered *employee's* home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Gene Therapy

Human gene therapy seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use. It is a technique that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms:

1. replacing a disease-causing gene with a healthy copy of the gene
2. inactivating a disease-causing gene that is not functioning properly
3. introducing a new or modified gene into the body to help treat a disease

Generic Drug

A *prescription drug* which has the equivalency of the *brand name* drug with the same use and metabolic disintegration. This *Plan* will consider as a generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information

Information about the genetic tests of an individual or their family members and information about the manifestations of *disease* or disorder in family members of the individual. A genetic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, which detects genotypes, mutations, or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested *disease*, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

The *Plan* complies with Title I of the Genetic Information Nondiscrimination Act of 2008 (GINA) as it applies to group health plans.

Habilitative Services/Habilitation Services

Habilitative services are intended to maintain, develop, or improve skills needed to perform activities of daily living (ADLs) or instrumental activities of daily living (IADLs) which have not (but normally would have) developed or which are at risk of being lost as a result of *illness*, *injury*, loss of a body part, or congenital abnormality.

Health Savings Account (HSA)

A tax-exempt or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you *incur*. You must be eligible to qualify for an HSA (refer to the **Schedule of Benefits** section of this document). Both *employer* and *employee* may contribute to an *HSA* in the same year. Annual

contribution limits are subject to IRS guidelines. Participation in a qualified *high deductible health plan* is required for participation in an *HSA* program.

High Deductible Health Plan (HDHP)

A medical plan with lower premiums and a minimum *deductible* amount set forth by federal law which is higher than a traditional health plan *deductible*.

Home Health Care Agency

An organization that meets all of these tests: its main function is to provide *home health care services and supplies*; it is federally certified as a home health care agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan

Must meet these tests: it must be a formal written plan made by the patient's attending *physician* which is reviewed at least every thirty (30) days; it must state the diagnosis; it must certify that the home health care is in place of *hospital* confinement; and it must specify the type and extent of *home health care services and supplies* required for the treatment of the patient.

Home Health Care Services and Supplies

Includes part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a *home health care agency* (this does not include general housekeeping services); physical, occupational, and speech therapy; medical supplies; and laboratory services by or on behalf of the *hospital*.

Hospice Care Agency

An organization whose main function is to provide *hospice care services and supplies* and is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan

A plan of terminal patient care that is established and conducted by a *hospice care agency* and supervised by a *physician*.

Hospice Care Services and Supplies

Provided through a *hospice care agency* and under a *hospice care plan* and includes *inpatient* care in a *hospice unit* or other licensed facility, and home health care, and family counseling during the bereavement period.

Hospice Unit

A facility or separate *hospital* unit that provides treatment under a *hospice care plan* and admits at least two (2) unrelated persons who are expected to die within six (6) months.

Hospital (Acute or Long-Term Acute Care Facility)

A provider licensed and operated as required by law, which provides all of the following and is fully accredited by The Joint Commission:

1. room, board, and nursing care
2. a staff with one (1) or more doctors on hand at all times
3. twenty-four (24) hour nursing service
4. all the facilities on site are needed to diagnose, care, and treat an *illness* or *injury*

The term hospital does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care

4. care of the aged
5. *custodial care*
6. educational care
7. subacute care

Refer to the defined terms for *Residential Treatment Facility* and *Substance Use Disorder/Mental Health Treatment Center* for the specific requirements applicable to those facility types.

Illness

A bodily disorder, congenital defects, *disease*, physical illness, or *mental disorder*. Includes *pregnancy*, childbirth, miscarriage, or complications of *pregnancy*.

Incurred

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

Independent Review Organization (IRO)

Please refer to the *Plan's* wrap document(s).

Infertility

Incapable of producing offspring.

Injury

An *accidental bodily injury*, which does not arise out of, which is not caused or contributed by, and which is not a consequence of, any employment or occupation for compensation or profit.

In-Network

See *Network*.

Inpatient

Treatment in an approved facility during the period when charges are made for *room and board*.

Institution

A facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a *hospital*, *ambulatory surgical center*, *psychiatric hospital*, community *mental health* center, *residential treatment facility*, psychiatric treatment facility, *substance use disorder treatment center*, alternative *birthing center*, home health care center, or any other such facility that the *Plan* approves.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a *hospital* solely for the care and treatment of patients who are critically *ill*. This also includes what is referred to as a coronary care unit or an acute care unit. It has facilities for special nursing care not available in regular rooms and wards of the *hospital*; special lifesaving equipment which is immediately available at all times; at least two (2) beds for the accommodation of the critically *ill*; and at least one (1) registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Investigational

See *Experimental/Investigational*.

Late Enrollee

A *plan participant* who enrolls under the *Plan* other than during the first thirty-one (31) day period in which the individual is eligible to enroll under the *Plan* or during a special enrollment period.

Leave of Absence

A period of time during which the *employee* does not work, but which is of a stated duration, after which time the *employee* is expected to return to active work.

Legal Guardian

A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Life-Threatening Disease or Condition

Any *disease* or condition from which the likelihood of death is probable unless the course of the *disease* is interrupted.

Long Term Acute Care Hospitals

Facilities that specialize in the treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures.

Long Term Care

Generally refers to non-medical care for patients who need assistance with basic daily activities such as dressing, bathing, and using the bathroom. Long-term care may be provided at home or in facilities that include nursing homes and assisted living.

Maintenance Care

Therapy or treatment intended primarily to maintain general physical condition, including, but not limited to routine, long-term, or maintenance care which is provided after the resolution of an acute medical problem. This includes services performed solely to preserve the present level of function or prevent regression for an *illness*, *injury*, or condition that is resolved or stable.

Mastectomy

The surgical removal of all or part of a breast.

Maximum Amount or Maximum Allowable Charge

The benefit payable for a specific coverage item or benefit under the *Plan*. Maximum allowable charge(s) will be based on one (1) of the following options, depending on the circumstances of the *claim* and at the discretion of the *Plan Administrator*:

1. *network* allowed amount
2. *network non-participating provider* rate
3. the negotiated rate established in a contractual arrangement with a provider
4. the *usual and customary* and/or *reasonable* amount
5. the actual billed charges for the covered services

The maximum allowed amount for emergency care from a *non-network* provider will be determined using the median *Plan network* contract rate paid to *network* providers for the geographic area where the service is provided.

The *Plan* has the discretionary authority to decide if a *charge* is *usual and customary* and/or *reasonable* for a *medically necessary* service. The maximum allowable charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Maximum Benefit

Any one (1) of the following, or any combination of the following:

1. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* during the entire time they are covered by this *Plan*
2. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* for a particular *covered charge*

   The *maximum amount* can be for either of the following:

   a. the entire time the *plan participant* is covered under this *Plan*
   b. a specified period of time, such as a *calendar year*
3. the maximum number as outlined in the *Plan* as a *covered charge*

   The maximum number relates to the number of:

   a. treatments during a specified period of time
   b. days of confinement
   c. visits by a *home health care agency*

Medical Care Facility

A *hospital*, a facility that treats one (1) or more specific ailments, or any type of *skilled nursing facility*.

Medical Child Support Order

Any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that mandates one (1) of the following:

1. provides for child support with respect to a *plan participant's* child or directs the *plan participant* to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law)
2. enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan

Please also refer to the *Plan's* wrap document(s).

Medical Emergency

A medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child)
2. serious impairment to body functions
3. serious dysfunction of any body organ or part

A medical emergency includes such conditions as heart attacks, cardiovascular *accidents*, poisonings, loss of consciousness or respiration, convulsions, or other such acute medical conditions.

Medical Management Administrator

A team of medical care professionals selected to conduct *pre-certification* review, *emergency* admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the **Health Care Management Program** section of this document.

Medical Non-Emergency Care

Care which can safely and adequately be provided other than in a *hospital*.

Medically Necessary/Medical Necessity

Care and treatment which is recommended or approved by a *physician*; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not

conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a *physician* recommends or approves certain care does not mean that it is medically necessary.

The *Plan Administrator* has the discretionary authority to decide whether care or treatment is medically necessary.

Medicare

The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder and Nervous Disorders/Substance Use Disorder

Any *disease* or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services, or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

Mental Health or Substance Use Disorder Hold

An involuntary detainment, by an officer of the court, in an *inpatient facility*, of an individual who is either posing a danger to themselves or others or determined to be gravely disabled due to a mental health condition. Typically lasting up to seventy-two (72) hours.

Network

An arrangement under which services are provided to *plan participants* through a select group of providers.

No-Fault Auto Insurance

The basic reparations provision of a law providing for payments without determining fault in connection with automobile *accidents*.

Non-Network

Services rendered by a *non-participating provider* within the designated *network* area.

Non-Participating Provider

A health care practitioner or health care facility that has not contracted directly with the *Plan*, *network*, or an entity contracting on behalf of the *Plan* to provide health care services to *plan participants*.

Notice/Notify/Notification

The delivery or furnishing of information to a *claimant* as required by federal law.

Open Enrollment Period

The annual period during which you and your *dependents* are eligible to enroll for coverage or change benefit plan options.

Other Plan

Shall include but is not limited to:

1. any primary payer besides the *Plan*
2. any other group health plan
3. any other coverage or policy covering the *plan participant*
4. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured, or underinsured motorist coverage
5. any policy of insurance from any insurance company or guarantor of a responsible party
6. any policy of insurance from any insurance company or guarantor of a third party

7. workers' compensation or other liability insurance company
8. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payment

Out-of-Network

See *Non-Network*.

Out-of-Pocket Limit

A *Plan's* limit on the amount a *plan participant* must pay out of their own pocket for medical expenses *incurred* during a *calendar year*. Out-of-pocket limits accumulate on an individual, family, or combined basis. After a *plan participant* reaches the out-of-pocket limit, the *Plan* pays benefits at a higher rate.

Outpatient

Treatment including services, supplies, and medicines provided and used at a *hospital* under the direction of a *physician* to a person not admitted as a registered bed patient; or services rendered in a *physician's* office, laboratory, or X-ray facility, *ambulatory surgical center*, or the patient's home.

Participating Provider

A health care provider or health care facility that has contracted directly with the *Plan* or an entity contracting on behalf of the *Plan* to provide health care services to *plan participants*.

Patient Protection and Affordable Care Act of 2010 (PPACA)

The Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Jointly, these laws are referred to as PPACA.

Pharmacy

A licensed establishment where covered *prescription drugs* are filled and dispensed by a pharmacist licensed under the laws of the state where they practice.

Physician

A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Audiologist, Certified Nurse Anesthetist, Doctor of Chiropractic (D.C.), Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of their license.

Plan

Please refer to the *Plan's* wrap document(s). Purdue University Welfare Benefit Plan is a distinct entity, separate from the legal entity that is your *employer*.

Plan Administrator

Please refer to the *Plan's* wrap document(s).

Plan Participant/Participant

Any *employee* or *dependent* who is covered under this *Plan*.

Plan Sponsor

Please refer to the *Plan's* wrap document(s).

Post-Service Claim

Please refer to the *Plan's* wrap document(s).

Pre-Admission Tests/Testing

Those *diagnostic services* done prior to scheduled *surgery*, provided that all of the following conditions are met:

1. The tests are approved by both the *hospital* and the *physician*.
2. The tests are performed on an *outpatient* basis prior to *hospital* admission.
3. The tests are performed at the *hospital* into which confinement is scheduled, or at a qualified facility designated by the *physician* who will perform the *surgery*.

Pre-Certification/Pre-Certified

An evaluation conducted by a utilization review team through the Health Care Management Program to determine the *medical necessity* and *reasonableness* of a *plan participant's* course of treatment.

Pregnancy

Childbirth and conditions associated with pregnancy, including complications.

Prescription Drug

Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed *physician*. Such drug must be *medically necessary* in the treatment of an *illness* or *injury*.

Pre-Service Claim

Please refer to the *Plan's* wrap document(s).

Preventive Care

Certain preventive services mandated under the *Patient Protection and Affordable Care Act of 2010 (PPACA)* which are available without cost sharing when received from a *network* provider. To comply with *PPACA*, and in accordance with the recommendations and guidelines, the *Plan* will provide *network* coverage for:

1. evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations
2. recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention
3. comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA)
4. comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA)

Copies of the recommendations and guidelines may be found here:
https://www.healthcare.gov/coverage/preventive-care-benefits/ or
http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

For more information, you may contact the *Plan Administrator/employer* as outlined in the Quick Reference Information Chart.

Primary Care Physician (PCP)

Family practitioners, general practitioners, geriatricians, pediatricians, internists, OBGYNs, and nurse practitioners and physician's assistants. All other *physicians* are considered specialists.

Prior Plan

The coverage provided on a group or group-type basis by the group insurance policy, benefit plan, or service plan that was terminated on the day before the effective date of the *Plan* and replaced by the *Plan*.

Prior to Effective Date or After Termination Date

Dates occurring before a *plan participant* gains eligibility from the *Plan*, or dates occurring after a *plan participant* loses eligibility from the *Plan*, as well as charges *incurred* prior to the effective date of coverage under the *Plan* or after coverage is terminated, unless extension of benefits applies.

Privacy Standards

The standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

Psychiatric Hospital

An *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospitals,* which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally *ill* persons either by, or under the supervision of, a *physician*.
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided.
3. It is licensed as a psychiatric hospital.
4. It requires that every patient be under the care of a *physician*.
5. It provides twenty-four (24) hour per day nursing service.

The term psychiatric hospital does not include an *institution,* or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care,* or educational care.

Qualified Individual

An individual who is a covered *participant* or beneficiary in this *Plan* and who meets the following conditions:

1. the individual is eligible to participate in an *approved clinical trial* according to the trial protocol with respect to the treatment of cancer or other *life-threatening disease or condition*; and
2. either:
    a. The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.
    b. The *participant* or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.

Qualified Medical Child Support Order (QMCSO)

A *medical child support order* that creates or recognizes the existence of an *alternate recipient's* right to, or assigns to an *alternate recipient* the right to, receive benefits for which a *plan participant* or eligible *dependent* is entitled under this *Plan.*

Reasonable

In the *Plan Administrator's* discretion, services, supplies, or fees for services or supplies which are necessary for the care and treatment of *illness* or *injury* not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the *Plan Administrator,* taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards, and practices as they relate to similar scenarios; and the cause of *injury* or *illness* necessitating the services and/or charges.

This determination will consider, but will not be limited to, the findings and assessments of the following entities:

1. The National Medical Associations, societies, and organizations
2. The Food and Drug Administration

To be reasonable, services and/or fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care, and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The *Plan Administrator* retains discretionary authority to determine whether services and/or fees are reasonable based upon information presented to the *Plan Administrator*. A finding of provider negligence and/or malpractice is not required for services and/or fees to be considered not reasonable.

Charges and/or services are not considered to be reasonable, and as such are not eligible for payment (exceed the *maximum allowable charge*), when they result from provider errors and/or facility-acquired conditions deemed reasonably preventable through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The *Plan* reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the *Plan* and to identify charges and/or services that are not reasonable and therefore not eligible for payment by the *Plan*.

Reconstructive/Reconstruction

Procedures are considered reconstructive when intended to address a significant variation from normal related to accidental *injury*, *disease*, trauma, treatment of a *disease*, or a congenital defect.

Rehabilitation Hospital

An *institution* which mainly provides therapeutic and restorative services to *ill* or *injured* people. It is recognized as such if it meets the following criteria:

1. It carries out its stated purpose under all relevant federal, state, and local laws.
2. It is accredited for its stated purpose by either The Joint Commission or the Commission on Accreditation for Rehabilitation Facilities.

Rehabilitation Services/Rehabilitative Services

Rehabilitative services are intended to improve, adapt, or restore functions which have been impaired or permanently lost as a result of *illness*, *injury*, loss of a body part, or congenital abnormality involving goals an individual can reach in a reasonable period of time. Benefits will end when treatment is no longer medically necessary and the individual stops progressing toward those goals.

Residential Treatment Center/Facility

A provider licensed and operated as required by law, which includes:

1. *room*, *board*, and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight (8) hours daily with twenty-four (24) hour availability
2. a staff with one (1) or more doctors available at all times
3. residential treatment takes place in a structured facility-based setting
4. the resources and programming to adequately diagnose, care, and treat a psychiatric and/or substance use disorder
5. facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care
6. is fully accredited by one of the following:
    - i. the Joint Commission (TJC)
    - ii. the Commission on Accreditation of Rehabilitation Facilities (CARF)
    - iii. the National Integrated Accreditation for Healthcare Organizations (NIAHO)
    - iv. the Council on Accreditation (COA)
    - v. Healthcare Facilities Accreditation Program (HFAP)
    - vi. DNV GL Healthcare (DNV)
    - vii. the Center for Improvement in Healthcare Quality (CIHQ)

The term residential treatment center/facility does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. *custodial care*
6. educational care

Room and Board

A *hospital's* charge for:

1. room and linen service
2. dietary service, including meals, special diets, and nourishment
3. general nursing service
4. other conditions of occupancy which are *medically necessary*

Security Standards

The final rule implementing HIPAA's security standards for the Protection of Electronic PHI, as amended.

Sickness

See *Disease*.

Skilled Nursing Facility

A facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an *inpatient* basis to persons recovering from an *injury* or *illness*. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a *physician*.
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, *custodial care*, or educational care.

Sound Natural Tooth

A tooth that is stable, functional, free from decay and advanced periodontal *disease*, and in good repair at the time of the *accident*.

Spinal Manipulation/Chiropractic Care

Skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a *physician* to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Substance Use Disorder/Mental Health Treatment Center

An *institution* which provides a program for the treatment of *substance use disorder* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be at least one (1) of the following:

1. affiliated with a *hospital* under a contractual agreement with an established system for patient referral
2. accredited as such a facility by The Joint Commission or CARF
3. licensed, certified, or approved as an alcohol or *substance use disorder* treatment program center, *psychiatric hospital,* or *facility* for *mental health* by a state agency having legal authority to do so
4. is a facility operating primarily for the treatment of *substance use disorder* and meets these tests:
    a. maintains permanent and full-time facilities for bed care and full-time confinement of at least twenty-four (24) hour-per-day nursing service by a registered nurse (R.N.)
    b. has a full-time psychiatrist or psychologist on the staff
    c. is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of *substance use disorder*

Substance Use Disorder

The DSM-5 definition is applied as follows: Substance use disorder describes a problematic pattern of using alcohol or another substance (whether obtained legally or illegally) that results in impairment in daily life or noticeable distress. An individual must display two (2) of the following eleven (11) symptoms within twelve (12) months:

1. consuming more alcohol or other substance than originally planned
2. worrying about stopping or consistently failed efforts to control one's use
3. spending a large amount of time using drugs/alcohol, or doing whatever is needed to obtain them
4. use of the substance results in failure to fulfill major role obligations such as at home, work, or school
5. craving the substance (alcohol or drug)
6. continuing the use of a substance despite health problems caused or worsened by it

    This can be in the domain of *mental health* (psychological problems may include depressed mood, sleep disturbance, anxiety, or blackouts) or physical health.
7. continuing the use of a substance despite its having negative effects in relationships with others (for example, using even though it leads to fights or despite people's objecting to it)
8. repeated use of the substance in a dangerous situation (for example, when having to operate heavy machinery, when driving a car)
9. giving up or reducing activities in a person's life because of the drug/alcohol use
10. building up a tolerance to the alcohol or drug

    Tolerance is defined by the DSM-5 as either needing to use noticeably larger amounts over time to get the desired effect or noticing less of an effect over time after repeated use of the same amount.
11. experiencing withdrawal symptoms after stopping use

    Withdrawal symptoms typically include, according to the DSM-5: anxiety, irritability, fatigue, nausea/vomiting, hand tremor, or seizure in the case of alcohol.

Surgery/Surgical Procedure

Any of the following:

1. the incision, excision, debridement, or cauterization of any organ or part of the body and the suturing of a wound
2. the manipulative reduction of a fracture or dislocation or the manipulation of a joint, including application of cast or traction
3. the removal by endoscopic means of a stone or other foreign object from any part of the body, or the diagnostic examination by endoscopic means of any part of the body
4. the induction of artificial pneumothorax and the injection of sclerosing solutions

5. arthrodesis, paracentesis, arthrocentesis, and all injections into the joints or bursa
6. obstetrical delivery and dilatation and curettage
7. biopsy
8. surgical injection

Temporomandibular Joint (TMJ)

The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves, and other tissues related to the temporomandibular joint.

Third Party Administrator

AmeriBen has been hired as the Third Party Administrator by the *Plan Administrator* to perform *claims* processing and other specified administrative services in relation to the *Plan*. The Third Party Administrator is not an insurer of health benefits under this *Plan*, is not a *fiduciary* of the *Plan*, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*. The Third Party Administrator is not responsible for *Plan* financing and does not guarantee the availability of benefits under this *Plan*.

Timely Payment

Please refer to the *Plan's* wrap document(s).

Total Disability/Totally Disabled

In the case of a *dependent* child, the complete inability, as a result of *injury* or *illness*, to perform the normal activities of a person of like age and sex and in good health.

Uniformed Services

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

Urgent Care Claim

Please refer to the *Plan's* wrap document(s).

Urgent Care Facility

A free-standing facility, regardless of its name, at which a *physician* is in attendance at all times that the facility is open, that is engaged primarily in providing minor *emergency* and episodic medical care to a *plan participant*.

Usual and Customary Charge

Covered charges which are identified by the *Plan Administrator*, taking into consideration the fees which the provider most frequently charges (or accepts) for the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same area by providers of similar training and experience for the service or supply, and the *Medicare* reimbursement rates. The term(s) 'same geographic locale' and/or 'area' shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons, or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be usual and customary, fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term 'usual' refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, *pharmacies*, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was *incurred*.

The term 'customary' refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one (1) individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale.

The term ‘usual and customary’ does not necessarily mean the actual charge made (or accepted), nor the specific service or supply furnished to a *plan participant* by a provider of services or supplies, such as a *physician*, therapist, nurse, *hospital*, or pharmacist. The *Plan Administrator* will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service, or supply is customary.

Usual and customary charges may, at the *Plan Administrator's* discretion, alternatively be determined and established by the *Plan* using normative data such as, but not limited to, *Medicare* cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer's retail pricing (MRP) for supplies and devices.

SECTION XX—PLAN ADOPTION

A. Severability

In the event that any provision of this document is held by a court of competent jurisdiction to be excessive in scope or otherwise invalid or unenforceable, such provision shall be adjusted rather than voided, if possible, so that it is enforceable to the maximum extent possible, and the validity and enforceability of the remaining provisions of this document will not in any way be affected or impaired thereby.

B. Adoption

Purdue University, hereby adopts the provisions of this Purdue University Welfare Benefit Plan, and its duly authorized officer has executed this summary plan description effective the first day of January 2026.

By: ______________________________ Date: _____________________________

Title: ____________________________

We’re here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here’s the English version: “You have the right to get help in your language for free. Just call the Member Services number on your ID card.” Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID
卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d’obtenir de l’aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d’identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d’autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht’s Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du’s besser sehne kannscht.

It’s important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don’t discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn’t English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator,
P.O. Box 7186 Boise, ID 83707, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**

If you have questions about your *Plan* benefits, please contact the *Third Party Administrator* at 1-833-782-9474.

AmeriBen

P.O. Box 7186
Boise ID 83707