SUMMARY PLAN DESCRIPTION
AND
PLAN DOCUMENT

FOR

THE TEACHERS HEALTH TRUST
SELF-FUNDED HEALTH BENEFIT PLAN
(Carve-Out Program)

As of January 1, 2024

ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document") is made by the Teachers Health Trust ("Plan Sponsor") as of January 1, 2024, and documents the Teachers Health Trust Self-funded Health Benefit Plan (Carve-Out Program) ("Plan").

Plan Sponsor was formed by the Clark County School District ("CCSD") and Clark County Education Association ("CCEA") to sponsor a self-funded employee welfare benefit plan ("THT Plan"), which is a government plan arising out of collective bargaining agreement pursuant to Chapter 288 of the Nevada Revised Statutes, not subject to ERISA pursuant to ERISA §3(32).

Plan Sponsor, with approval from CCSD and CCEA, has created the Plan to be a "carve-out" program under and subject to the THT Plan to provide Participants who reside in the geographic areas of Mesquite and Moapa Valley, Nevada (including without limitation, Overton, Logandale, and Caliente), St. George, Utah and certain other small rural communities in states neighboring to Nevada in which such Participants reside (collectively, the "Carve-Out Area"), with the benefits substantially the same as set forth in the THT Plan, but administered by Educators Health Plans Life, Accident, and Health, Inc. ("EMI Health").

EFFECTIVE DATE
The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein ("Effective Date").

ADOPTION OF THE PLAN DOCUMENT
The Plan Sponsor hereby adopts this Plan Document as the written description of the Plan as of the Effective Date.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed as of the Effective Date.

PLAN SPONSOR:

TEACHERS HEALTH TRUST

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GENERAL PLAN INFORMATION

TEACHERS HEALTH TRUST has adopted this Plan for the benefit of its Eligible Employees and their Eligible Dependents. This document provides a summary of the benefits provided under the Plan as of January 1, 2024, and is also the formal plan document of the Plan.

Please note that capitalized terms used in this document are defined either the first time they are used or in the "Definition of Terms" section at the end of this document.

TYPE OF PLAN

All benefits under the Plan are self-insured by the Plan Sponsor. Benefits under the Plan are funded by contributions from the Clark County School District in an amount established in a Collective Bargaining Agreement between the Clark County School District and the Clark County Education Association. EMI Health does not insure any benefits under the Plan.

TYPE OF ADMINISTRATION

The Plan Sponsor is the Plan Administrator. The Plan Sponsor has entered into an agreement with EMI Health as a third-party administrator to assist the Plan Sponsor in the Plan's claims administration and certain other administrative matters.

PLAN NAME

The Teachers Health Trust Self-Funded Health Benefit Plan (Carve-Out Program)

EFFECTIVE DATE OF PLAN: January 1, 2024

PLAN YEAR ENDS: December 31, 2024

RENEWAL

This Plan may automatically be renewed for 12-month terms unless the Plan Sponsor notifies EMI Health in writing of its intent to terminate the Plan at least 60 days prior to the end of the current term.

PLAN SPONSOR INFORMATION

Teachers Health Trust
2950 E. Rochelle Avenue
Las Vegas, Nevada 89121
Telephone: (702) 780-0898
Email: rwright@ththealth.org

PLAN SPONSOR TIN: 88-0195176

PLAN ADMINISTRATOR

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Email: rwright@ththealth.org

NAMED FIDUCIARY

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TEACHERS HEALTH TRUST BOARD OF TRUSTEES

Michael Steinbrink, Chairperson
Isela Stellato, Vice-Chairperson
David Tatlock, Secretary
Jodi Brant, Trustee
Cindy Johnson, Trustee
Molly Lehman, Trustee
Kerri Martinez Najera, Trustee
Cynthia Rapazzini, Trustee
Vikki Courtney, CCEA President, Trustee

AGENT FOR SERVICE OF LEGAL PROCESS

Teachers Health Trust
2950 E. Rochelle Avenue
Las Vegas, Nevada 89121
Telephone: (702) 780-0898
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CLAIMS ADMINISTRATOR

EMI Health
5101 S. Commerce Dr.
Murray, Utah 84107
Telephone: (801) 262-7476
Fax: (801) 269-9734
Website: https://emihealth.com

PLAN STATUS: Non-Grandfathered

GROUP NUMBER: 4087

PLAN TYPE: Medical; Prescription Drug

AMENDMENT OR TERMINATION

The Plan Sponsor reserves the right to modify, suspend, or terminate the Plan at any time. The Plan Sponsor does not promise the continuation of any benefits nor does it promise any specific level of benefits at or during retirement.

The Table of Allowances may be updated as deemed necessary by the Plan Sponsor and EMI Health. After the effective date of a change in the Table of Allowances, all benefits will be paid according to the new Table of Allowances.

Benefit changes to this Plan will apply to all Covered Persons on the date amended benefits become effective.

The terms of this Plan may not be amended by oral statements made by the Plan Sponsor, the Plan Administrator, the Claims Administrator, or any other person. In the event an oral statement conflicts with the written terms of this Plan, the Plan terms will control.

RELATIONSHIP TO TEACHERS HEALTH TRUST PLAN (THT PLAN)

The Plan is a carve-out of the THT Plan for those Participants whose primary residence is located in the Carve-Out Area. The EMI Health Care Plus Medical, Choice Dental, and VSP Vision benefits provided under the Plan are provided in lieu of and are comparable to the medical, dental and vision benefits provided under the THT Plan.

YOUR RIGHTS

As a Covered Person in the Plan, you are entitled to certain rights and protections as follows:

- Receive Information about Your Plan and Benefits

  - Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan.
  - Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, and a summary plan description. The Plan Administrator may make a reasonable charge for the copies.
  - Receive a summary of this Plan's annual financial report.

- Continue Group Health Plan Coverage

  - Continue health care coverage for yourself, your Spouse, or Eligible Dependents, if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Eligible Dependents may have to pay for such coverage. Review this document for the rules governing your COBRA continuation coverage rights.

- Prudent Action by Plan Fiduciaries

  - The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Participants and other Plan participants and beneficiaries. No one, including the employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit you are entitled to or exercising your legal rights.

- Enforce Your Rights

  - If your claim for a benefit is denied or ignored, in whole or in part, you have the 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. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

- Assistance with Your Questions

    - If you have any questions about this Plan, you should contact the Plan Administrator.

NOT A CONTRACT

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the employer and any Participant or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this Plan Document shall be deemed to give any employee the right to be retained in the service of the employer or to interfere with the right of the employer to discharge any employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the employer with the bargaining representatives of any employees.

MENTAL HEALTH PARITY

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

DISCRETIONARY AUTHORITY

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants' rights; and to determine all questions of fact and law arising under the Plan.

ELIGIBILITY AND PARTICIPATION

Eligibility

An employee and his dependents are eligible for participation and coverage under this Plan if the employee is an Eligible Employee, and the Eligible Employee's primary residence is located in the Carve-Out Area. Dependents of the Eligible Employee eligible for coverage include dependent children from birth to the 26th birthday and the Eligible Employee's Spouse or eligible Domestic Partner. Children may include stepchildren, an eligible Domestic Partner's children, legally adopted children, children legally placed for adoption, and children for whom the Eligible Employee has legal guardianship.

Children may include foster children if all of the following conditions are met:

- The child lives with the Eligible Employee;
- The parent-child relationship is with the Eligible Employee, not solely the child's biological parent;
- The Eligible Employee is the primary source of financial support for the child; and
- The Eligible Employee expects to raise the child to adulthood.

An Eligible Dependent child's coverage may be extended beyond the 26th birthday if the child is incapable of self-sustaining employment due to a mental or physical disability and is chiefly dependent on the Participant for support and maintenance. The Participant must furnish written proof of disability and dependency to Plan Sponsor and Claims Administrator within 31 days after the child reaches 26 years of age. The Claims Administrator may require subsequent proof of disability and dependency after the child reaches age 26, but not more often than annually. (Please refer to Eligible Dependent in the "Definition of Terms" section for more information.)

Domestic Partner Eligibility

For Nevada residents, a Domestic Partner relationship exists when the Domestic Partners have registered with the Office of the Secretary of State of Nevada and have obtained a Certificate of Registered Domestic Partnership. For more information on how to register as Domestic Partners with the State of Nevada, visit www.nvsos.gov and click on the Domestic Partner Registration link. To review a list of frequently asked questions related to the domestic partnership laws, visit Plan Sponsor's website at www.teachershealthtrust.org.

For residents of all states other than Nevada, to be eligible as a Domestic Partner, the Participant and Domestic Partner must be recognized as legally married in the state in which the marriage was performed or registered as domestic partners in the state in which they reside.

The Subscriber and Domestic Partner must submit an enrollment form and "Affidavit of Domestic Partnership" (Exhibit 1) to the Plan Sponsor. The affidavit must confirm the Domestic Partner's eligibility under the Plan.

The Plan Sponsor is responsible to determine that the foregoing requirements for domestic partnership are satisfied. The Plan Sponsor shall provide copies of documentation to EMI Health upon request.

Changes in Covered Person Information

Participants should notify Plan Sponsor within 31 days whenever there is a change in a Covered Person's situation that may affect the Covered Person's enrollment eligibility or status.

Enrollment

To enroll, the Eligible Employee must complete an enrollment application and file it with the Plan Sponsor within 31 days of his employment date, or during a subsequent Open Enrollment period. A Participant is not entitled to change his coverage elections during the Plan Year, except as provided in the *Special Enrollment* section.

When Coverage Begins

If the Eligible Employee enrolls within 31 days of his employment, the Eligible Employee's coverage (and the coverage of his Eligible Dependents, if such Eligible Dependents were also enrolled during such 31-day period) becomes effective the first day of the month coinciding with or following the date of hire.

If the Eligible Employee enrolls during a subsequent Open Enrollment period, the Eligible Employee's coverage (and the coverage of his Eligible Dependents, if such Eligible Dependents were also enrolled during such Open Enrollment period) becomes effective the first day of the following Plan Year.

If the Eligible Employee enrolls during a Special Enrollment period, the Eligible Employee's coverage (and the coverage of his Eligible Dependents, if such Eligible Dependents were also enrolled during such Special Enrollment period) becomes effective as provided in the *Special Enrollment* section.

Special Enrollment

Special Enrollment Period when Other Coverage Terminates

If an Eligible Employee declined participation for himself and/or his Eligible Dependents, and, when enrollment was previously declined, the Eligible Employee and/or his Eligible Dependents were covered under another group plan or had other insurance coverage, the Eligible Employee will have a Special Enrollment period if when the Eligible Employee declined enrollment for himself and/or his Eligible Dependents, the Eligible Employee and/or his Eligible Dependents

1. Had COBRA continuation coverage under another plan and such continuation coverage has since been exhausted, and the Eligible Employee elects coverage for himself or herself and/or his or her Eligible Dependents by making an election with the Plan Sponsor, in the manner prescribed by the Plan Sponsor within 31 days of such cessation; or

2. Had coverage through Medicaid or the Children's Health Insurance Program (CHIP) that has been terminated as a result of loss of eligibility of coverage, and the Eligible Employee elects coverage for himself or herself and/or his or her Eligible Dependents

by making an election with the Plan Sponsor, in the manner prescribed by the Plan Sponsor within 60 days of such cessation; or

3. If the other coverage was not under COBRA, Medicaid, or CHIP, either the other coverage has been terminated as a result of loss of eligibility for coverage or employer contributions towards such coverage have been terminated, and the Eligible Employee elects coverage for himself or herself and/or his or her Eligible Dependents by making an election with the Plan Sponsor, in the manner prescribed by the Plan Sponsor within 31 days of such cessation. (Note: Loss of eligibility of coverage includes a loss due to legal separation, divorce, death, termination of employment, reduction in hours worked, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or intentional misrepresentation.)

If the Eligible Employee meets the above conditions, coverage under the Plan will be effective as of the date such previous coverage ceased.

Special Enrollment Period for Acquisition of Eligible Dependent
The Eligible Employee and/or his new Eligible Dependent may enroll for coverage (even if He previously declined coverage for himself and/or his Eligible Dependents) if the Eligible Employee acquires such new Eligible Dependent due to marriage, birth, adoption, or placement for adoption. In addition, the Eligible Employee may also enroll his Dependent Spouse if the Eligible Employee acquires a new Eligible Dependent due to marriage, birth, adoption, or placement for adoption. To enroll during this Special Enrollment period, the Eligible Employee must enroll within 31 days of the event (e.g., marriage, birth, adoption, or placement for adoption). Coverage will be effective as follows:

1. In the case of marriage, the marriage date; or

2. In the case of an Eligible Dependent's birth, the date of such birth; or

3. In the case of adoption, or placement for adoption, the coverage of an adopted child of a Participant is provided from the moment of birth, if placement for adoption occurs within 30 days of the child's birth, or beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth.

Special Enrollment Period for Change of Principal Residence
The Eligible Employee and/or his Eligible Dependents may enroll for coverage under the Plan (even if He previously declined coverage for himself and/or his Eligible Dependents) if the Eligible Employee relocates his principal residence to within the Carve-Out Area. To enroll during this Special Enrollment period, the Eligible Employee must enroll within 31 days of the event. Coverage under the Plan will be effective the first day of the month immediately following enrollment.

Termination of Coverage

Unless eligible for continuation coverage under COBRA, a Covered Person's participation under the Plan ceases on the earliest of the following:

- For the Participant and covered Eligible Dependents, the last day of the calendar month coinciding with or following the Participant's termination of employment or when the Participant's employment position or status changes such that he is no longer an Eligible Employee, unless specific provisions in the employer's policy manual apply;

- For the Participant and covered Eligible Dependents, the last day of the month for which coverage has been paid, subject to a 31-day Grace Period, in the event any required Participant contributions are not made;

- For covered Eligible Dependents, other than the Participant's Spouse or Domestic Partner, the individual ceases to be an Eligible Dependent on the last day of the calendar month coinciding with the Eligible Dependent's 26th birthday;

- For covered Spouse, the last day of the calendar month coinciding with the date the divorce from the Participant is final;

- For the Domestic Partner and the Domestic Partner's covered children, the date the domestic partnership is dissolved. A "Statement of Termination of Domestic Partnership" (Exhibit 2) must be submitted to Plan Sponsor as notification of the dissolution of domestic partnership. Plan Sponsor may accept the Subscriber's request to remove the Domestic Partner and children from the Plan without confirmation from the Domestic Partner. If the domestic partner relationship ends, the former Domestic Partner (and his/her children) may continue coverage under COBRA;

- For the Participant and covered Eligible Dependents, the date specified in any Plan amendment resulting in loss of eligibility;

- For the Participant and covered Eligible Dependents, the date this Plan is terminated; or

- For any Covered Person, the discovery of fraud or misrepresentation on the part of the Covered Person in either the enrollment process or in the use of services or facilities, including any misuse of a Plan ID card. (Note: If a Covered Person's coverage is terminated for cause, the termination of coverage will relate back to the effective date of coverage and the Plan Sponsor may recover any overpayments from the Covered Person such that the Plan Sponsor and the Covered Person are returned to the same financial position as if no coverage had ever been in force. Termination of a Participant's coverage for cause will also result in the termination of coverage of the Participant's covered Eligible Dependents.)

A Participant is not entitled to voluntarily terminate coverage for himself or his covered Eligible Dependents during the Plan Year, unless He experiences a Special Enrollment qualifying event (e.g. marriage, divorce, birth, death, adoption, placement for adoption, or loss of other insurance coverage). If the Participant experiences a Special Enrollment qualifying event He may elect to terminate coverage for himself and/or his Eligible Dependents by making an election with the Plan Sponsor, in the manner prescribed by the Plan Sponsor, within 31 days of such event.

Family Medical Leave Act (FMLA)

A Participant who goes on a leave under the Family Medical Leave Act (FMLA) has the following rights during such leave:

- A Participant may continue his coverage and the coverage of his covered Eligible Dependents during an FMLA leave provided He continues to pay any required Participant portion of the cost of such coverage in accordance with the Plan Sponsor's FMLA leave policy. The Plan Sponsor will continue to make the same contributions toward that coverage that it would have made had the Participant not taken FMLA leave.

- If the Participant portion of the cost of coverage is not paid, the Participant's and covered Eligible Dependents' coverage will be terminated 31 days after the due date of any required payment. Upon the Participant's return to work, the Participant's coverage and the coverage of any previously covered Eligible Dependents, will be reinstated as long as the Participant returns to work before or immediately following the expiration of the FMLA leave. If the Participant does not return to work before or immediately following the expiration of the FMLA leave, the Participant will be treated as a new employee upon his return and will be entitled to elect coverage for himself and his Eligible Dependents in accordance with the rules applicable to new employees.

Military Leave

Pursuant to the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), a Participant who is on military duty with a uniformed service has certain rights. If the period of duty is less than 31 days, coverage will be maintained if the Participant pays any required Participant contribution. If the period of duty is for more than 31 days, the Plan Sponsor must permit the Participant to continue coverage under rules similar to COBRA. The maximum coverage period is the lesser of 24 months or the period of duty. A Participant receiving coverage under USERRA shall be required to pay 102 percent of the applicable premium. No waiting period can be imposed on a returning Participant and his Eligible Dependents if the period would have been satisfied had the Participant's coverage not terminated due to the duty leave.

Qualified Medical Child Support Orders

Upon receipt of a National Medical Support Notice requiring the Participant to provide coverage for an Eligible Dependent child, the Plan Sponsor will comply with all applicable requirements of the Notice and applicable law.

Benefits for Employees Working Beyond Age 65

If a Participant becomes eligible for Medicare solely as a result of attaining age 65, the Participant will have the option of electing coverage under this Plan, in which case this Plan is primary and Medicare is secondary. Alternatively, the Participant may elect to terminate coverage under this Plan and choose Medicare as his primary coverage. If a Participant chooses Medicare as his primary plan, the Participant may not elect this Plan as his secondary plan. If the Participant elects to terminate coverage under this Plan, coverage will also be terminated for his Eligible Dependents.

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 secondary (as described under "Coordination of Benefits"). The Participant will be assumed to have full Medicare coverage (that is, both Parts A and B) whether or not the Participant has enrolled for the full coverage. If

the Provider accepts assignment with Medicare, Eligible Expenses will not exceed the Medicare-approved expenses.

Medicare Services Furnished to End Stage Renal Disease ("ESRD")

If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

Contact the Plan Sponsor or the EMI Health Enrollment Department for information.

Using the Care Plus Benefits

Covered Persons should always carry their EMI Health Care Plus Medical Identification / Prescription Drug Cards so that Participating Providers can determine what the Covered Person is required to pay, how to bill the Plan, and when to preauthorize major services.

- Covered Persons generally should go to an EMI Health Care Plus primary care physician (PCP) first. EMI Health Care Plus PCPs are specialists in family practice, internal medicine, pediatrics, and obstetrics or gynecology. PCPs provide primary care and can help coordinate secondary Provider care. If the Covered Person chooses to see a secondary care or ancillary care participating physician, He may pay a higher Copayment.

- A directory of Participating Providers will be furnished free of charge as a separate document. The Covered Person may also obtain a copy of the directory of Participating Providers from the Plan Sponsor, on the Internet at www.emihealth.com, or by calling 801-270-2880.

- The EMI Health Care Plus Plan provides the following levels of care:

    1. Covered Persons are eligible for Participating Provider Option benefits when receiving care from Participating Providers.
    2. Covered Persons may choose to receive care from Non-participating Providers. However, when a Covered Person receives care from a Non-participating Provider, benefits are determined based on the Non-participating Provider Option (see "Summary of Benefits" chart). These benefits are less than the corresponding benefits under the Participating Provider Option.

Although benefits under the Plan are generally greater for services provided by Participating Providers, the choice to use a Participating Provider or Non-participating Provider is entirely up to the Covered Person. EMI Health does not employ Participating Providers, and they are not agents or partners of EMI Health. Providers participate in the network only as independent contractors. Participating Provider status is not an endorsement or representation by the Plan Sponsor, Plan Administrator, or EMI Health as to the qualifications (or quality of care) of any particular Provider.

- **Advantages of Using Participating Providers**. When Covered Persons elect to use Participating Providers, they enjoy the following advantages over Non-participating Providers:

    - The Provider bills the Plan for them;
    - The Provider accepts the Plan's Maximum Allowable Charges and agrees not to bill Covered Persons for excess of the Maximum Allowable Charge for covered services; and
    - The Provider agrees to obtain Preauthorization from the Plan for Covered Persons for major services.

- Covered Persons should verify their Providers' panel status at the time of each visit by following these steps:

- Contact Providers to assure that they are Participating Providers with EMI Health.
- Contact EMI Health Customer Service Department.

The Table of Allowances is the schedule established by EMI Health, on behalf of Plan Sponsor, for payment of eligible charges**. All benefits outlined in this Plan are subject to the Maximum Allowable Charge. For example, if a Provider charges $125 for a procedure for which the Table of Allowances permits $100 payment, the Plan will pay the specified percentage of $100, not $125.**

When Non-participating Provider Option Benefits Apply

Participating Provider Option benefits are available when the care is provided through a Participating Provider. Non-participating Provider Option benefits offer Covered Persons the flexibility to use any Non-participating Provider or facility.

In cases where the Covered Person uses a participating facility but uses a non-participating physician, Participating Provider Option benefits will apply to services from the participating facility, while Non-participating Provider Option benefits, which may require more payment by the Covered Person, will apply to services rendered by the non-participating physician.

- **Using Non-participating Providers and Facilities**. When the Covered Person elects to use Non-participating Providers and facilities

  - The Covered Person must obtain Preauthorization from the Plan for major services. (Refer to the *Preauthorization Requirements* section.)
  - The benefits may be less, and in some cases, there may be no benefits available under the Non-participating Provider Option.
  - The Covered Person is responsible for any billed charges exceeding the Maximum Allowable Charge for covered services.

Even in the unlikely event that there is no Participating Provider available to perform the services needed, the Plan will not pay Participating Provider Option benefits to a Non-participating Provider. Non-participating Provider Option benefits will apply.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is designed to insure against financial hardship caused by unexpected expenses from catastrophic Illness. When a Covered Person has satisfied any applicable Deductible and paid Eligible Expenses, including eligible Copayments, up to the Out-of-Pocket Maximum, the Plan will pay remaining Eligible Expenses at 100 percent of the Maximum Allowable Charge. Amounts paid by a manufacturer, drug manufacturer, provider, facility, vendor, or any other provider of healthcare services will not accumulate towards the Out-of-Pocket Maximum.

When a Covered Person receives any service or treatment specified as a limited benefit, the Plan will pay for services only up to the specified amounts.

Any payment made by the Covered Person for amounts in excess of the limits, and expenses the Covered Person pays if He does not follow Preauthorization procedures, will not accumulate toward the annual Deductible or Out-of-Pocket Maximum.

The Participating Provider and Non-participating Provider Options each have a separate Out-of-Pocket Maximum.

Benefit Accumulations

All Deductibles, Out-of-Pocket Maximums, benefit limits, etc. accumulate on a Calendar Year basis, beginning January 1, and ending December 31.

Care Plus Preauthorization Requirements

"Preauthorization" is the procedure for confirming, prior to the rendering of care, the medical necessity and appropriateness of the proposed treatment, and whether (and if so, to what extent) such treatment is a covered benefit for the Covered Person. Whether Preauthorization is required, and if so, how and when it must be obtained, depends on the kind of treatment and whether the Provider is a Participating Provider or a Non-participating Provider.

- **The following kinds of treatments require Preauthorization:**

  - Hospitalizations and Inpatient facility admissions, including skilled nursing facilities and mental health and drug/alcohol treatment
  - Residential treatment
  - Surgeries in a Hospital or ambulatory surgical facility, including Injectables and infusions
  - Major Diagnostic Testing
  - Capsule endoscopy
  - Skin substitutes
  - Home Health services, including home I.V. services
  - Dental services, including orthodontics, when dental injury occurs as a result of an Accident
  - Durable Medical Equipment and Prostheses
  - Hyperbaric oxygen treatment
  - Clinical Trials
  - Flight-based inter-facility patient transport services when using a Non-participating air ambulance service
  - Unlisted, temporary, or supplemental tracking codes

- **If the Covered Person uses a Participating Provider,** for any of the above treatments or procedures, **the Provider** (not the Covered Person) is responsible for Preauthorization**. The Covered Person is advised to verify with the physician that Preauthorization procedures have been followed.**

- **If the Covered Person uses a Non-participating Provider** for any of the above treatments or procedures **the Covered Person (even in an emergency) is responsible for obtaining Preauthorization, and benefits may be denied or reduced if the Covered Person fails to timely obtain Preauthorization**, as follows:

  - To obtain Preauthorization for Durable Medical Equipment or Prostheses submit, to EMI Health, a written request accompanied by a letter of Medical Necessity.
  - To obtain Preauthorization for all other services, call 1-801-270-3037 or (toll free) 1-888-223-6866.

- For services or treatments that require Inpatient hospitalization, other than emergencies, the Covered Person must obtain Preauthorization at least 48 hours prior to receiving the services or treatments.
- **For emergency hospitalizations, the Covered Person must give notice of the hospitalization within 48 hours of the admission**, or as soon as reasonably possible, by calling one of the phone numbers listed above. An appropriate length of hospitalization will then be determined.
- If a Covered Person responsible for obtaining Preauthorization fails to do so in the required time, EMI Health will review the treatment and apply the following penalties:
  - If the treatment is for non-emergency services, benefits will be denied.
  - If the treatment is for emergency services, benefits will be reduced by 50 percent (per admission for Inpatient hospitalization, or per service or procedure, for the others listed above).
  - Any amount paid out-of-pocket for failing to follow Preauthorization requirements is not applied toward the Out-of-Pocket Maximum.

Preauthorization Review Process

If the Claims Administrator denies a request for Preauthorization based on a determination of Medical Necessity and appropriateness which a Covered Person believes is properly compensable under the applicable terms of the Plan, the Covered Person may within the time limits provided below after receipt of notice of denial of Preauthorization request a review by the Plan's Utilization Review by calling 1-801-270-3037 or toll free 1-888-223-6866. If the Covered Person disagrees with the finding of the Plan's Utilization Review regarding services, He may request a second review.

If the Claims Administrator denies a request for Preauthorization based on Plan benefits or eligibility which a Covered Person believes is properly compensable under the applicable terms of the Plan, the Covered Person may within the time limits provided below after receipt of notice of denial of Preauthorization appeal the denial. If the Covered Person disagrees with the finding of the first level review, He may request a second level review the results of which shall be reported, with all appropriate documentation, to Plan Administrator's Board of Trustees, who shall have final authority over the review decision.

If the Covered Person disagrees with the outcome of the preauthorization review, the Covered Person shall have a right to pursue any remedies available at law or equity.

No action at law or in equity may be brought against the Plan until the Covered Person has exhausted the Preauthorization Review Process, as provided in this section.

1. **Urgent Preauthorization Requests**. The following time limits and rules regarding modes of communication shall apply to Urgent Preauthorization Requests:

(i) If the Covered Person fails to follow the procedures for submitting the Preauthorization request, the Plan will notify the Covered Person of the failure and the proper procedures within 24 hours after the failure. The notice may be given orally unless the Covered Person requests written notice.

(ii) If the Covered Person submits an incomplete Preauthorization request, the Plan will provide notice that the Preauthorization request is incomplete and of the

missing information within 24 hours after receiving the incomplete Preauthorization request. The notice may be given orally unless the Covered Person requests written notice. The Covered Person will have 48 hours after receiving notice of the incomplete Preauthorization request to provide the additional required information, which may be provided by telephone, fax, or similar method.

(iii) The Plan will then provide notice of its initial decision on the Preauthorization request within (a) 72 hours after receiving the completed Preauthorization request or after the expiration of the Covered Person's 48-hour period to provide additional information, whichever is earlier, or (b) 72 hours after receiving the initial Preauthorization request, if it was proper and complete when submitted. The notice may be made orally if written or electronic notice is provided within three days after oral notification.

(iv) If the Preauthorization request is denied in whole or part, the Covered Person has 180 days after receiving the Preauthorization request denial to request an appeal of the decision. The request and any additional information to support the appeal may be provided by telephone, fax, or similar method.

(v) The Plan will provide its decision on appeal within 72 hours after receiving the request for appeal.

2. **Non-urgent Preauthorization Requests**. The following time limits and modes of communication shall apply to non-urgent Preauthorization requests:

(i) If the Covered Person fails to follow the procedures for submitting the Preauthorization request, the Plan will notify the Covered Person of the failure and the proper procedures within five days after the failure. The notice may be given orally unless the Covered Person requests written notice.

(ii) The Plan will provide notice of its decision on the Preauthorization request within (a) 15 days after receiving initial Preauthorization request, or (b) 30 days after receiving the Preauthorization request, if the Plan determines that an extension is necessary due to matters beyond the control of the Plan and the Plan provides an extension notice during the initial 15-day period. If the extension is due to the Covered Person's failure to submit information necessary to decide a Preauthorization request, the extension notice will identify the additional information necessary for the Plan to decide the Preauthorization request, and the Covered Person will have at least 45 days from the date of such notice to provide the additional information. The period for making the benefit determination will be tolled from the date on which the notification of the extension is sent until the date on which the Covered Person provides the additional required information.

(iii) If the Preauthorization request is denied in whole or in part, the Covered Person has 180 days after receiving the Preauthorization request denial to request a first level appeal of the decision. The request and any additional information to support the appeal must be made in writing.

(iv) The Plan will provide its decision on the first level appeal within 15 days after receiving the request for appeal.

(v) If the Preauthorization request is denied in whole or in part on the first level appeal, the Covered Person has 60 days after receiving the decision to request a second level appeal. The request and any additional information to support the appeal must be made in writing.

(vi) The Plan will provide its decision on the second level appeal within 15 days after receiving the request for appeal.

Second Opinion

In order to determine whether any proposed or continuing care, diagnosis, treatment, service, surgical procedure, diagnostic or medical procedure, drug therapy, blood transfusion, or other covered service (collectively the "Recommended Care") is Medically Necessary and appropriate, the Plan may, at any time, require at its own expense a Covered Person to obtain a second (and third, if necessary) opinion from a Participating Provider, selected by the Plan, regarding such recommended care.

Inform EMI Health of Changes

The Participant must either call EMI Health Enrollment Department or submit an Enrollment Application to notify the Plan of a change in his address or telephone number. The Participant must use the Enrollment Application to make other changes, such as changes to name and/or marital status, as well as to add or delete family members to the Plan. Enrollment Applications are submitted to the Plan Sponsor. (See the *Eligibility and Participation* section for guidelines on adding new Eligible Dependents.) The Plan Sponsor will forward copies of all Enrollment Applications to EMI Health.

COVERED MEDICAL BENEFITS

ALL OF THE FOLLOWING OUTLINED BENEFITS ARE FOR THE PARTICIPATING PROVIDER OPTION. IF NON-PARTICIPATING PROVIDERS ARE USED, BENEFITS WILL BE REDUCED TO THE AMOUNT SHOWN UNDER THE NON-PARTICIPATING PROVIDER OPTION COLUMN OF THE SUMMARY OF BENEFITS.

Hospital/Facility Benefits

This section provides a general summary of Hospital and Facility Benefits available under the Participating Provider Option. For details as to specific coverages, see the "Summary of Benefits" chart. This section does not apply to Physician and Professional Services, which are addressed separately in this Plan and in the "Summary of Benefits" chart.

Hospitalizations and Inpatient surgeries require Preauthorization. **The Covered Person is advised to verify with the physician that Preauthorization procedures have been followed**. The Plan provides benefits for the following:

- Semi-private room and intensive care charges.

- Hospital Ancillary Charges, including operating room, dressings and supplies, and Hospital Outpatient Services rendered in connection with surgery for which the operating room and other Hospital facilities are needed. Hospital Ancillary Charges include, but are not limited to, the following:

  - Drugs
  - Operating room
  - Medical Supplies
  - X-ray and laboratory expenses
  - Electrocardiograms
  - Chemotherapy or radiation therapy
  - Inhalation therapy
  - Intravenous therapy

- Skilled nursing facility services, up to a maximum of 30 days per year. Admission to a skilled nursing facility must occur within five days of a discharge from a Hospital Confinement.

- Outpatient surgery facility expenses. Some procedures require Preauthorization. Please refer to the list of procedures under the *Preauthorization Requirement* section of this contract.

- Major Diagnostic Testing.

Emergency Room (ER) Service Benefit

The Plan provides benefits for the following:

- Medically Necessary and appropriate ER services are covered according to the "Summary of Benefits" chart.

- Although payment of the ER Copayment/Coinsurance amount is not required before service may be provided in the ER, it is the Covered Person's responsibility to pay the ER

Copayment/Coinsurance listed on the "Summary of Benefits" chart directly to the providing facility.

- The ER Copayment/Coinsurance covers the facility charges only. The Covered Person may have additional physician and professional charges according to the "Summary of Benefits" chart.

If the Covered Person is admitted directly to the Hospital as an Inpatient because of the condition for which ER services were sought, then the ER Copayment/Coinsurance will be waived. The usual Copayment/Coinsurance amounts normally applied to such a hospitalization will be required.

Inpatient Rehabilitation Therapy Benefit

The Plan provides benefits for all services and treatments in connection with Inpatient rehabilitation therapy (limited to physical, speech, occupational, cardiac, and pulmonary). Inpatient benefits are limited to a combined maximum of 40 days per person per year.

Emergency Care and Life-threatening Condition Benefits

The Plan provides benefits for the following:

- Expenses for Emergency Care and Life-threatening conditions. Participating Provider benefits, up to the Maximum Allowable Charge, apply to initial treatment regardless of whether services are received from a Participating or Non-participating Provider. However, if the Covered Person is subsequently admitted to a Non-participating Hospital, he or she may be required to transfer to a participating Hospital once the emergency condition has been stabilized in order to continue receiving Participating Provider benefits.

- Services provided by a licensed ambulance service for necessary transportation to and from a Hospital, doctor's office, clinic, or other medical institution when the Covered Person's condition is deemed to be a Life-threatening Condition. For a patient who is in a Hospital or other healthcare facility under the care or supervision of a licensed healthcare Provider, Preauthorization is required before transport of the patient via a Non-participating air transport to another Hospital or facility. Failure to obtain a Preauthorization may, solely in the Plan's discretion, result in a reduction or denial of benefits for charges arising from or related to inter-facility patient transport via air. Penalties for failing to follow Preauthorization requirements are not applied toward the Out-of-Pocket Maximum. The Plan retains the authority to limit benefit availability to Providers of flight-based inter-facility patient transport if and when a Provider fails to comply with the terms of the Plan, or billed charges exceed the Maximum Allowable Charges in accordance with the terms of the Plan.

- Expenses for repairs of physical damage to sound natural teeth, crowns, and the natural supporting structure surrounding teeth when the following conditions are met. Requires Preauthorization.

    - Such damage is a direct result of an Accident independent of disease or any other cause;
    - Medical advice, diagnosis, care, or treatment was recommended or received for the Covered Person at the time of the Accident and
    - Repairs are initiated within one year of the date of the Accident.

Physician and Professional Services

The Plan provides benefits for the following:

- Convenience clinic visits.
- Physician office visits and after-hours physician office visits.
- Inpatient Hospital physician visits.
- Routine prenatal physician visits and delivery expenses. This includes visits and delivery for the pregnancy of an Eligible Dependent. A Covered Person may choose to deliver on an outpatient basis. The length of a Hospital stay after a delivery is based on Medical Necessity and appropriateness, except that the Plan Sponsor and/or EMI Health may not restrict benefits for any Hospital stay in connection with childbirth for a mother or newborn child for less than 48 hours following a normal vaginal delivery, or for less than 96 hours following a cesarean section, and may not require that a Provider obtain authorization from EMI Health for prescribing a length of stay not in excess of the above periods. The mother or the newborn child's attending Provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours or 96 hours, as applicable.
- Surgical and anesthetic procedures including the following. Incidental Surgical Procedures or incidental scar excisions are excluded from coverage.
    - Multiple or bilateral surgical procedures.
    - Surgical procedures rendered during Inpatient hospitalization, as an outpatient, or in a physician's office.
    - Treatment of fractures or dislocations and orthopedic casting.
    - Operative and major diagnostic endoscopic procedures.
    - Therapeutic surgical injections and aspirations, biopsies, and destruction of lesions by chemical, mechanical, or electrical means.
    - Operative and curative procedures rendered by a podiatrist for the treatment of diseases of the feet.
    - Surgical and anesthetic benefits cover expenses incurred for medical treatment rendered on the date of any surgical procedure or during a reasonable convalescent period following any surgery.
    - Physiological conditions resulting from corrective procedures that are not directly related to a previous Reconstructive, Cosmetic, or Plastic Surgery; for example, anesthetic complications, myocardial infarction, venous thrombosis, or anaphylactic reaction.
    - Pump implantation, medication, and related services for Baclofen for the following diagnoses, when criteria are met:
        - Cerebral palsy
        - Brain and spinal cord injuries
        - Multiple sclerosis
        - Post stroke hypertonia
        - Post traumatic brain injury
        - Dystonia in children and generalized secondary dystonia

- Benefits for the primary surgeon performing a surgical procedure. Pre-operative and post-operative services within the global period of the surgical procedure are included in the allowable surgeon's fee.

- Benefits for an assistant surgeon, only when Medically Necessary and appropriate.

- Benefits for a co-surgeon in the absence of an assistant surgeon, in cases where two surgeons are involved in the same procedure, and if both sets of operative notes indicate the use of co-surgeons.

- Expenses for an anesthesiologist.

- Preadmission testing.

- Laboratory and X-ray charges.

- Home Health/Skilled Nursing Care, including charges of a qualified licensed practitioner for approved skilled nursing services. Certain Injectables are covered only under the Prescription Card. See the "Prescription Drug Program" for details.

- Hospice Care Services and Supplies, only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months, and placed the person under a Hospice Care Plan.

- Rehabilitation therapy (limited to physical, speech, occupational, cardiac, and pulmonary) must be given to improve the physical capabilities of a Covered Person in an attempt to restore the individual to a previous level of good health. (Outpatient benefits may be limited. See Summary of Benefits for details.)

- Chiropractic adjustments of the vertebral column and its immediate articulations, up to a maximum of 20 visits per person per year, subject to EMI Health's criteria.

- Acupuncture, up to a maximum of 20 visits per person per year.

- Allergy testing.

- Allergy serum.

- Chemotherapeutic medications.

- Hemophiliac medications.

Preventive Care Services

The Plan provides benefits for evidence based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force. These include, but are not limited to, the following:

- One Routine Physical Examination per person per year
- One Routine Gynecological Examination per person per year
- One family history examination per person per year
- One routine Pap smear per person per year
- One routine mammogram per person per year
- One Routine Hearing Exam per person per year
- One Routine Vision Exam per person per year
- Routine well-baby care
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). For current recommendations, refer to http://www.cdc.gov/vaccines/schedules/index.html. Immunizations, other than those described above, are not covered even if deemed Medically Necessary or administered at the advice of a PCP or any other Provider.

Transplant Benefits

The Plan will provide benefits for expenses incurred in connection with liver, bone marrow, heart, pancreas, cornea, lung, and kidney Transplants, including presurgery testing, medical expenses incurred by the donor and/or recipient directly as a result of the Transplant process, and the cost of transporting the donated organ, and prescribed medications to inhibit rejection of the Transplant ("Transplant Benefits"). Coverage for a living donor includes only the costs directly associated with the acquisition of the organ. Any ongoing care associated with complications or Secondary Medical Conditions for the donor is not covered. Transplants must be preauthorized and meet specific medical criteria in order for Transplant Benefits to apply. Covered services shall include only those services or supplies provided in connection with a heart, pancreas, cornea, lung, liver, kidney, or bone marrow Transplant that are within the scope of the Transplant Benefits, and shall expressly exclude all other services or supplies provided in connection with an organ Transplant. Non-covered Transplant services or supplies include but are not limited to, the following:

- Any intestine Transplant
- Any Transplant of a non-human organ or non-human bone marrow
- Any services or supplies in connection with the implantation of any artificial organ or device, regardless of whether implantation is a temporary measure while awaiting an available human organ

Medical Supplies and Equipment

The Plan provides benefits for the following:

- Medical Supplies including, but not limited to, ileostomy supplies, I.V. therapy, oxygen, and surgical dressings.

- Diabetes test strips, insulin syringes, and lancets.

- Durable Medical Equipment. Rental of Durable Medical Equipment (not to exceed purchase price) when Medically Necessary and appropriate for therapeutic use, unless the purchase of an item of Durable Medical Equipment will be less expensive than rental or if such equipment is not available for rental. In most cases, the Plan will make payment on the standard model of Durable Medical Equipment. If additional items of comfort or convenience are desired, it will be the Covered Person's responsibility to pay for them. Repair or replacement of existing Durable Medical Equipment for reasons other than normal physical growth will be considered no more than once every five years.

- Prostheses. Expenses in connection with a Prosthesis will be covered no more than once every five years, except replacement will be covered if the replacement is Medically Necessary due to normal physical growth of the Covered Person.

- Orthotic devices of the feet.

- Growth hormones.

- Pacemakers. Expenses in connection with a pacemaker will be covered no more than once every five years.

- Deep brain stimulation for treatment of Parkinson's disease when the patient meets EMI Health's criteria, a copy of which will be provided upon request.

- Ventricular Assist Devices (VADs), including Left, Right, and Biventricular Assist Devices, when the patient meets EMI Health's criteria, a copy of which will be provided upon request.

- Cochlear implants when the patient meets EMI Health's criteria, a copy of which will be provided upon request.

Clinical Trials

The Plan covers routine costs related to a Qualified Individual's participation in an Approved Clinical Trial. Routine costs of a clinical trial include all items and services that are otherwise generally available to Covered Persons (i.e., there exists a benefit category; it is not statutorily excluded; and there is not a national non-coverage decision) that are provided in either the experimental or the control arms of a clinical trial. Requires Preauthorization.

Qualified Individual is someone who is eligible to participate in an "Approved Clinical Trial" and either the Covered Person's doctor has concluded that participation is appropriate or the Covered Person provides medical and scientific information establishing that participation is appropriate.

Approved Clinical Trial is defined as a Phase I, II, III, or IV clinical trial for the prevention, detection, or treatment of cancer or other life-threatening condition or disease (or other condition described in the Affordable Care Act, such as federal funded trials, conducted under an

investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application). A life-threatening condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted.
A Participating Provider must be used if there is a Participating Provider that is participating in an Approved Clinical Trial.

Non-covered services or supplies include, but are not limited to, the following:

- The investigational item or service, itself, unless otherwise covered outside of the clinical trial
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g. monthly CT scans for a condition usually requiring only a single scan)
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial

Mental Health and Drug/Alcohol Treatment

Mental Health and Drug/Alcohol Treatment will be considered for payment only when provided by a person licensed to provide individual psychotherapy, including a psychiatrist, licensed clinical psychologist, licensed social worker, and/or advanced practice registered nurse. The Plan provides benefits for the following:

- Inpatient Mental Health and Drug/Alcohol Treatment. Requires Preauthorization.
- Residential treatment services, up to a maximum of 30 days per year. Requires Preauthorization.
- Partial hospitalization and intensive outpatient services.
- Physician office visits.

Additional Benefits

The following benefits are available only if specific medical criteria are met. The portion a Covered Person pays for these benefits may not apply toward the Out-of-Pocket Maximum. The Plan provides benefits for the following:

- Hearing aids, including repair and replacement every five years
- Wig or hairpiece following chemotherapy or radiation
- Diagnosis and non-surgical treatment of temporomandibular joint dysfunction (TMJ)
- Total parenteral nutrition (TPN), for both Inpatient and outpatient treatment
- Initial assessment and diagnosis of Primary Infertility
- Reduction mammoplasty, when criteria are met

Women's Cancer Rights

The Plan provides medical and surgical benefits for mastectomies for the diagnosis of breast cancer and other Medically Necessary diagnoses required by the Women's Health and Cancer Rights Act of 1998, and will comply with all the requirements of the Act, including coverage for the following:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and Reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and coverage for complications, including lymphedemas

Cost Reform Information

Medical cost reform is a high priority for the Plan Sponsor, who is eager to help Covered Persons become better-informed health care consumers which, in turn, will provide for more efficient use of the medical benefits under this Plan. The following information is presented in an effort to assist Covered Persons in making better-informed decisions.

- **Admission the Day of Surgery (Same-day Surgery)**
  Many surgeries can be performed on the same day of admission to the Hospital. This means the necessary testing and preliminary operative workup should take place before admission on either an outpatient basis or on the day of surgery.

- **Home Health/Skilled Nursing Care and I.V. Therapy**
  As part of the Plan Sponsor's commitment to medical cost reform, they will arrange for Home Health/Skilled Nursing Care and I.V. therapy if a Covered Person chooses to leave the Hospital earlier than the days allowed for his particular Illness. Please contact EMI Health for more information on this program or to make arrangements for Home Health Care. Any reduction in the length of stay must have the full knowledge and consent of the physician.

- **Office Surgery**
  Many procedures may be performed in a physician's office rather than a Hospital. The Covered Person should ask his physician if the proposed surgery is suitable to be performed as an office surgery.

- **Outpatient Procedures**
  Due to advances in medical technology and patient care, it is now possible to have surgery and return home the same day. This type of surgery, known by various terms such as "one-day surgery," "ambulatory surgery," "same-day surgery," and "outpatient surgery," can be performed in a special facility at a Hospital or in a licensed independent Surgical Center.

  There are many advantages to outpatient surgery. The first obvious advantage is in the area of cost. There is also the advantage of reduced emotional stress, especially with children. There is also less time spent away from home, thus avoiding needless interruptions in the Covered Person's routine and family activities.

- **Second Opinions**
  There are instances when it may be advisable to obtain a second opinion for surgery. If the Covered Person has questions regarding a second opinion, He should contact the EMI

Health's Customer Service Department for assistance. If the Plan requests a second opinion, the Maximum Allowable Charge will be paid in full by the Plan, in accordance with this Plan Document.

- **Abuse of Benefits**
  If the Plan determines that a Covered Person is attempting to abuse the benefits (which may include, but is not limited to, jumping from Provider to Provider, excessive emergency room visits, or seeking medications from multiple sources), the Plan has the right to place the Covered Person on a "Medical Compliance Plan." The Covered Person will be required to receive care from specific Providers that are named in the Medical Compliance Plan in order to receive benefits under the Plan. If a Covered Person on a Medical Compliance Plan chooses to receive care from Providers that are not in the Medical Compliance Plan, benefits will be denied.

- **Hospital Bill Audits**
  The purpose of the Hospital bill audit is to protect the Covered Person and the Plan from billing errors and unnecessary services. Through these Hospital bill audits, the Plan can help assure that the level of care and the services received are compatible with the amount billed.

  Hospital Confinements in which the Hospital charges are over the threshold amount will be evaluated to determine if an audit is necessary. In addition, Hospital bills of less than the threshold amount will be prescreened for billing irregularities and audited when appropriate.

- **Billing Accuracy**
  In most cases, the Covered Person knows better than anyone the medical care that He has received. By reviewing Provider billings for accuracy, the Covered Person can make certain that there are no duplicate or incorrect charges. The Covered Person should report any possible discrepancies to EMI Health's Customer Service Department.

- **Claims Edit System**
  The American Medical Association publishes standards for the coding of medical procedures. Healthcare Providers are expected to bill for services based on these guidelines, but errors occasionally occur. EMI Health uses a claims edit system that is programmed to help identify inappropriate billing codes or coding combinations. Any charges that are denied as a result of this claims edit system are identified as such on the Covered Person's Explanation of Benefits. These amounts represent Provider adjustments and are not the patient's responsibility. Covered Persons should contact EMI Health if they believe that they are being billed for claims edit system denials.

MEDICAL PLAN EXCLUSIONS

Notwithstanding anything else in the Plan to the contrary, the items listed below are not covered by the Plan.

The Plan does not pay for the following:

1. Services received by a Covered Person before coverage under the Plan became effective or after coverage under the Plan has terminated.

2. Services not specified as covered. There is no presumption of coverage.

3. Care, supplies, treatment, and/or services that are not payable under the Plan due to application of any Plan maximum or limit or because the billed charges are in excess of the Maximum Allowable Charge, or are for services not deemed to be reasonable or Medically Necessary and appropriate, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

4. Any Copayments or Deductibles incurred under this policy, except as they are applied to the Out-of-Pocket Maximum where applicable.

5. Illness or injury caused by the negligent or wrongful act of another, or for which the Covered Person is covered by any workers' compensation or similar law; except that the Plan may advance benefits to or on behalf of the Covered Person in such situations, subject to the Plan's right of Subrogation and reimbursement set forth herein.

6. Illness or injury that a Covered Person incurred either (1) while in the service of a Plan Sponsor that was obligated by law to provide workers' compensation insurance that would have covered such Illness or injury, or, (2) while in the service of a Plan Sponsor that had elected to exclude workers' compensation coverage for such Covered Person, except that the Plan may elect to advance benefits to or on behalf of the Covered Person in either situation, subject to the Plan's right to Subrogation and reimbursement set forth herein.

7. Illness or injury for which the Covered Person is covered by other responsible insurance including, but not limited to, coverage under a government sponsored health plan, underinsured motorist coverage, or uninsured motorist coverage, except as otherwise provided herein.

8. Care, supplies, treatment, and/or services for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

9. Care, supplies, treatment, and/or services that are expenses to the extent paid, or which the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government.

10. 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.

11. Except as otherwise provided by law, charges for Hospital Confinement, services, supplies, or treatment the Covered Person is not legally required to pay.

12. Charges for Hospital Confinement, services, supplies, or treatment received while the Covered Person is incarcerated in a correctional facility.

13. Coverage for Illness or injury as a result of war or any act of war, whether declared or undeclared, or caused while performing service in the armed forces of any country.

14. Charges for procedures, supplies, equipment, and services which are not Medically Necessary and appropriate.

15. Care, supplies, treatment and/or services that do not restore health, unless specifically mentioned otherwise.

16. Care, treatment, or services provided when there are no symptoms of Illness or injury, or when there is or has been no diagnosis of Illness or injury.

17. Care, treatment, or surgical procedures incurred primarily for convenience, contentment, or other non-therapeutic purposes.

18. Expenses in connection with immunizations other than those that have in effect a recommendation from the Advisory Committee on Immunizations Practices of the Center for Disease Controls and Prevention (CDC).

19. Expenses for personal hygiene, convenience, wellness, or preventive care including, but not limited to, buildings, motor vehicles, air conditioners, whirlpool baths, exercise equipment, or other multi-purpose equipment or facilities, related appurtenances, controls, accessories, or modifications thereof.

20. Convenience items in or out of the Hospital such as guest trays, cots, telephone calls, and other services.

21. Expenses for preparing medical reports, itemized bills, or claim forms.

22. Expenses for shipping, handling, postage, sales tax, interest, finance charges, and other administrative charges.

23. Transportation expenses including, but not limited to, mileage reimbursement, airfare, meals, accommodations, and car rental.

24. Ancillary Charges made by a medical institution, Hospital, clinic, hospice, nursing home, or similar facility to hold or reserve a room during any temporary leave of absence of the Covered Person, or in anticipation of a Hospital stay.

25. Additional reimbursement based upon the technique, approach, or instrument used in treatment. Payment is based on the standard base-level method of treatment only.

26. Any care, treatment, or expenses for Cosmetic procedures or complications thereof, including Reconstructive or corrective procedures done primarily for Cosmetic purposes. A care, treatment, or procedure is considered Cosmetic when it is primarily intended to improve appearance or correct a deformity without restoring physical bodily function. Psychological factors such as, but not limited to, poor self-image or difficult peer or social relations are not relevant and do not justify a Cosmetic procedure as being Medically Necessary and appropriate. The reversal of a non-covered Cosmetic procedure is not covered. This exclusion does not apply to Reconstructive Surgery performed or treatment required under the Women's Health and Cancer Rights Act of 1998.

27. Care, treatment, services, or surgical procedures rendered for abdominoplasties, diastasis recti abdominous, protruding ears, breast enlargement, or gynecomastia, or for complications thereof.

28. Care, treatment, services, or surgical procedures rendered for reduction mammoplasty, unless the patient meets the Plan's criteria, a copy of which will be provided upon request.

29. Care, treatment, services, or surgical procedures rendered for blepharoplasty, unless the patient meets EMI Health's criteria, a copy of which will be provided upon request.

30. Health services and associated expenses for the surgical treatment and non-surgical medical treatment of obesity (whether morbid obesity or not) including, but not limited to, weight loss programs, except for evidence based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force. (For guidelines refer to http://bit.ly/USPSTF_AB.)

31. Expenses in connection with any Bariatric surgery including, but not limited to, gastric banding, gastric stapling, or digestive bypass, or for complications thereof.

32. Educational or behavioral modification services or counseling including, but not limited to, biofeedback, weight control clinics, stop-smoking clinics, cholesterol counseling, exercise programs, or other types of physical fitness training, except for evidence based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force. (For guidelines refer to http://bit.ly/USPSTF_AB.)

33. Confinement, education, or training in a nursing home, rest home, or similar establishment, including an institution that is primarily a school or other institution for training, except an Extended Care Facility as provided in this Plan.

34. Expenses in connection with Custodial Care.

35. Charges in connection with institutional care, including residential treatment or programs, which as determined by the Plan, is for the primary purpose of controlling or changing the environment for the individual.

36. Charges for cognitive therapy.

37. Care or treatment of learning disorders, intellectual disabilities, or chronic organic brain syndrome, except services required to diagnose any of the above.

38. Treatment or services for marriage counseling and any counseling or psychotherapy for relief of family or marital discord, divorce, preparation for marriage, encounter groups, parental counseling, treatment for situational disturbances such as financial or environmental problems, or other types of everyday stresses and strains.

39. Expenses for treatment of personality disorders, behavior disorders, or chronic situational reactions; occupational, religious, or other social maladjustment; or non-specific conditions such as acts of impulse including, but not limited to, gambling, pyromania, and kleptomania.

40. Care, treatment, procedures, or services for psychosexual dysfunction. This exclusion does not apply to the initial assessment and diagnosis of the condition.

41. Care, supplies, treatment, and/or services for any Injury or Illness which is incurred while voluntarily taking part, or attempting to take part, in an Act of Aggression or an illegal activity, including but not limited to misdemeanors and felonies. 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. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

42. Infertility services including, but not limited to, the following. This exclusion does not apply to the initial assessment and diagnosis of the condition.

- Artificial insemination, sperm washing, sperm banking, and/or storage.
- Donor costs.
- Experimental or Investigative treatment.
- Gamete intrafallopian transfer (“GIFT”).
- Hamster egg penetration tests.
- In-vitro fertilization (IVF).
- Medications for Infertility and ultrasounds associated with Infertility medications therapy.
- Non-participating Provider or facility services for Infertility.
- Zygote intrafallopian transfer (“ZIFT”).
- Surrogate mothers.
- Secondary Infertility.
- Expenses in connection with retrieval or collection of semen and/or ovum.

43. The reversal of a surgically performed sterilization, subsequent sterilization, or ovulation-inducing drugs or injections.

44. Expenses in connection with abortion, except as follows:

- Where documented by medical evidence that the life of the mother would be endangered if the fetus were carried to term.
- Where the pregnancy is the result of incest or rape.

45. Care, treatment, or surgical procedures for erectile dysfunction.

46. Care, treatment, or devices to aid in female sexual arousal disorder including, but not limited to, Eros Clitoral Therapy Device.

47. Expenses in connection with a penile prosthesis.

48. All organ Transplant services when rendered by Non-participating Providers.

49. Services for cross matching and/or harvesting organs from live or deceased donors for all non-covered Transplant/Implant services and whenever the organ recipient is not a Covered Person.

50. Repair or replacement of any otherwise covered Implant when rendered by non-participating Providers.

51. Expenses for and in connection with artificial hearts.

52. Duplication, upgrade, improvement, or alteration of existing Durable Medical Equipment. This includes parts, such as but not limited to, batteries. Replacement of existing Durable Medical Equipment will be covered if the replacement is Medically Necessary due to normal physical growth of the Covered Person. Repair or replacement of existing Durable Medical Equipment for reasons other than normal physical growth will be considered no more than once every five years. Expenses related to modifications and/or improvements to home, van, or other vehicle, regardless of Medical Necessity are excluded. This exclusion does not apply to medical supplies for use with insulin pumps and/or insulin infusion pumps.

53. Charges for Durable Medical Equipment, medical supplies, medication, or lab tests that are purchased via the internet from Non-participating Providers or vendors, or for which a prescription or physician order is not required.

54. Eyeglasses, contact lenses, or the fitting of eyeglasses or contact lenses, with the exception of one lens per operated eye following eye surgery; for example, an external contact lens or surgically implanted intraocular lens. This exclusion does not apply to contact lenses for Keratoconus diagnosis.

55. Radial keratotomy or lamellar keratectomy, or other eye surgery performed primarily to correct refractive errors.

56. Orthoptic training or vision therapy.

57. Dental, mouth, and jaw services including, but not limited to, all care, treatment, therapy, surgery, or diagnostic procedures for the following, unless otherwise indicated in the "Summary of Benefits" chart:

- Appliances, bite guards, space maintainers, splints
- Bone resection, bone screws, Implants
- Crowns or caps, dentures, permanent bridgework
- Endodontics, nerves within the teeth
- Full mouth rehabilitation therapy
- Injection of joints
- Maxillary and or mandibular osteotomy
- Orthodontic treatment
- Orthognathic procedures, upper/lower jaw augmentation or reduction procedures, including problems due to development or altering of vertical dimensions
- Periodontics, gums alveolar processes
- Prosthodontic treatment
- Restorations, including restoration of occlusion
- Teeth, including nursing bottle syndrome, caries, etc.
- X-rays
- Temporomandibular joint disorders (TMJ)
- Removal of impacted teeth

58. Dental anesthesia. This exclusion does not apply to covered oral surgery, or when treatment is for a Covered Person who is four years old or younger or who has a medical condition that makes dental anesthesia Medically Necessary.

59. Services, supplies, or accommodations provided in connection with the following:

- Routine cutting, removal, or other treatment of corns, calluses, or toenails unless deemed Medically Necessary and appropriate due to infection or a metabolic disease such as diabetes mellitus or a peripheral vascular disease such as arteriosclerosis.
- Orthopedic shoes that are not attached to a brace.

60. Expenses for whole blood, or blood derivatives.

61. Complementary and Alternative Medicine, including but not limited to acupressure/acupuncture, dry needling, hippotherapy (also known as equine-assisted therapy), or hypnosis. This exclusion does not include otherwise covered chiropractic care as described in the *Covered Medical Benefits* section.

62. Care, treatment, surgical procedures or supplies, or any appliances, aids, devices, or drugs that are illegal, Experimental, or Investigative as defined in the Plan, or for complications thereof.

63. Care, treatment, supplies, appliance, aids, devices, or drugs that are 1) not approved by the FDA for the particular medical indication, or 2) are still under investigation, and current peer-reviewed studies or national professional guidelines do not indicate superiority or significant improvement over current, accepted stands of care.

64. Care, treatment, or services including, but not limited to, testing associated with autogenous urine immunization, sublingual provocation, leukocytoxicity, and subcutaneous provocation and neutralizing.

65. Expenses in connection with herbal, holistic, or homeopathic treatment, or for complications thereof.

66. Expenses for services in connection with Bioidentical Hormone therapy.

67. Food supplements including vitamins, minerals, and herbs, plus enteral nutrition products, formulas, pasteurized human milk, and medical food that are administered orally and any related supplies.

68. Genetic, molecular, or gene-based testing except for tests on the Plan's approved list and when the member meets the specific criteria. Genetic counseling unless required by the Affordable Care Act.

69. Expenses for gene therapy, adoptive immunotherapy, and cellular therapy, except for therapy on the Plan's approved list and when the member meets specific criteria.

70. Expenses related to a sleep laboratory or facility, except services related to sleep apnea, unless otherwise indicated. This includes, but is not limited to, insomnia.

71. Expenses for any of the following:

- Ambulance services when the individual could be safely transported by means other than ambulance
- Air ambulance services when the Covered Person could be safely transported by ground ambulance or by means other than ambulance. The Plan retains authority to limit benefit availability to Providers of inter-facility air transport if and when a Provider fails to comply with the terms of the Plan or billed charges exceed the Maximum Allowable Charge in accordance with the terms of the Plan.
- Ambulance services beyond transportation to the nearest facility expected to have appropriate services for the treatment of the injury or Illness involved
- Ambulance services for conditions, other than injuries received in an Accident, not deemed Life-threatening.

72. Special duty nursing services, including the following:

- That ordinarily would be provided by the Hospital staff or its Intensive Care unit. (The Hospital benefit pays for general nursing service by Hospital staff.)
- Requested by, or for the convenience of, the Covered Person or the Covered Person's family or consisting primarily of bathing, feeding, exercising, housekeeping, moving the Covered Person, giving medication, or acting as a companion or sitter, or when otherwise deemed not to be Medically Necessary and appropriate.
- Rendered by a private duty nurse, unless billed by the Home Health agency.
- Home Health aides or services.

73. Charges for physician calls in excess of one per physician per day, or for a mid-level provider and the supervising Physician in the same day.

74. Expenses for appointments scheduled but not kept.

75. Expenses for the following services delivered remotely via telephone, email, or other telecommunication technologies:

- Asynchronous telecommunication
- Services delivered via systems that are not HIPAA compliant
- Communication for which the lone purpose is to obtain a referral to specialty care services
- Triage to assess the appropriate place of service or appropriate healthcare provider
- Incidental services, such as reporting of test results, administrative matters, requests for medication refills, or ordering diagnostic studies
- Telemedicine that occurs the same day as a face-to-face visit with the same Provider for the same patient
- More than one telemedicine visit a day with the same Provider for the same patient
- New patient visits
- Services offered through vendor-contracted or kiosk delivery systems other than EMI TeleMed.

76. Care, treatment, or services rendered by any Provider who ordinarily resides in the same household (e.g. Spouse, parent).

77. Services performed by a Provider type that is not covered by the Plan including, but not limited to, the following:

- Doctor of education
- Home Health aide
- Nurse's aide
- Hygienist
- Hypnotist
- Medical assistant
- Massage therapist
- Naturopath
- Vocational nurse
- Personal fitness trainer/coach
- Non-physician technician
- Birthing center
- Non-accredited facilities

78. All self-administered Injectables. (Refer to "Prescription Drug Program.") This exclusion does not apply to the following:

- Neupogen (Filgrastim)
- Epogen, Procrit (Epoetin Alfa)

- Lupron, Lupron Depot, Lupron Depot-3 month, Lupron Depot-4 month, Lupron Depot-Ped, Lupron Depot-Gyn, Oaklide (Leuprolide Acetate)
- Neulasta (Pegfilgrastim)
- Neumagea (Oprelvekin)
- Leukine, Prokine (Saragramostim)

79. All medications that are excluded under the "Prescription Drug Program" are also excluded under Medical. This exclusion does not apply to the following (under Medical plan):

    - Chemotherapeutic medications.
    - Otherwise covered medication which is to be taken by, or administered to, an individual, in whole or in part, while He is a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, skilled nursing facility, convalescent Hospital, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
    - Any otherwise covered drug provided under another provision of the policy; e.g. Inpatient Hospital use.
    - Medically Necessary and appropriate enteral feeding when administered via nasogastric, gastrotomy, or jejunostomy tube.

80. All services, equipment, and supplies provided or ordered to treat complications or Secondary Medical Conditions of a non-covered Illness, injury, condition, situation, procedure, or treatment.

81. Elective or non-emergent care, supplies, or services received outside of the United States or from a non-U.S. Provider.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a medical condition.

PRESCRIPTION DRUG PROGRAM

The prescription drug program is separate from the medical plans outlined in this document. Coinsurance and Copayments for prescriptions may not apply toward the medical plan Deductible or Out-of-Pocket Maximum.

Copayment and Coinsurance

Copayments and Coinsurances are listed in the "Summary of Benefits" chart. The Participating Pharmacy line indicates the amount the Covered Persons must pay if they purchase prescriptions at a participating pharmacy.

Covered Drugs

This program provides benefits for medications that require a prescription under state or federal law unless listed under the "Prescription Drug and Home Delivery Pharmacy Service Exclusions" section.

Covered Persons receive up to a 30-day supply per Copayment. A maximum of two vials of insulin per Copayment is allowed. When necessary, additional vials may be purchased during the month by paying an additional Copayment.

This prescription drug program covers lancets, insulin syringes, and test strips only if purchased at a participating pharmacy (see the Participating Pharmacy list). Lancets, insulin syringes, and test strips are also covered under the Medical Supplies and Equipment benefit.

Medications will be reviewed by the Plan for coverage within 90 days of notification to the Plan of FDA approval. Medications will be placed on the Pharmacy Benefit Manager's formulary tier after review. These reviews are not retro-active to the FDA approval date. Medications will not be approved for experimental uses or non-FDA approved indications.

This program reviews prescribing, dispensing, and consumption patterns for potential abuse. The program may also involve the review of claims for drug interactions, drug conflicts, duplicate therapies, overutilization, and/or clinically appropriate maximum daily dose limits.

The Plan may limit the availability and filling of any prescription drug that is susceptible to abuse. The Plan may require a Covered Person to

- Obtain prescription in limited dosages and supplies
- Obtain prescriptions only from a specified Provider
- Fill prescriptions at a specified pharmacy
- Participate in a specified treatment for any underlying medical problem, such as but not limited to, a pain management program
- Complete a drug treatment program

- Adhere to any other specified limitation or program designed to reduce or eliminate drug abuse or dependence

If a Covered Person seeks to obtain drugs in amounts in excess of what is Medically Necessary, such as making repeated emergency room or urgent care visits to obtain drugs, the Plan may deny coverage of any medication susceptible to abuse.

Specialty Pharmacy

Specialty medications are typically bio-engineered and have specific shipping and handling requirements or are required to be dispensed by a specific facility. EMI Health has partnered with Accredo to assist in dispensing most specialty drugs.

Receiving the specialty drug from Accredo will help assure that the Covered Person will pay the lowest cost. EMI Health requires that specialty medications be obtained from Accredo. Specialty medications may not be obtained through a regular retail pharmacy.

Option 1 – The Covered Person contacts Accredo

Step 1: If required, once the Preauthorization is approved, the Covered Person will call Accredo at 1-800-803-2523 between 6:00 a.m. and 6:00 p.m., Mountain Time, Monday through Friday.

Step 2: Accredo will contact the Covered Person's Physician and make appropriate arrangements.

Step 3: Accredo will contact the Covered Person to arrange delivery.

Option 2 – The Physician calls Accredo

Step 1: The Covered Person will provide the Physician with his or her member ID number (located on the prescription drug ID card) and ask the Physician to contact Accredo at 800-803-2523.

Step 2: Accredo will contact the Covered Person or the Covered Person's Physician to arrange delivery.

Mandatory Generic

If the Covered Person chooses to have a pharmacy fill a prescription with a brand-name medication rather than the generic medication that is available, the Covered Person will pay the difference in cost between the generic and the brand-name medication.

Generic medications are products that contain the same active ingredient as their brand-name counterparts, in the same dosage form and strength. Although generic medications can differ in size, shape and/or color, the generic medication offers the same effectiveness as the brand-name medication.

Step Therapy

Certain Prescription Drugs are subject to Step Therapy review. Step Therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug, and stepping up through a sequence of alternative drug therapies as a preceding treatment option fails. If Step Therapy criteria are not met Preauthorization will be required. For additional information, the Covered Person should contact the prescription drug program customer service telephone number printed on the back of the EMI Health ID card.

How to Use the Prescription Card

1. Use participating pharmacies. A list of participating pharmacies may be obtained by calling the telephone number printed on the back of the EMI Health ID card.
2. Present the EMI Health ID card whenever purchasing eligible prescription drugs.
3. Pay the applicable Copayment at the time of purchase. (Some maintenance drugs may be available through the mail-order program. See "Home Delivery Pharmacy Service Program" section.)
4. If the Covered Person has a prescription filled at a non-participating pharmacy, He will pay the pharmacy's full regular price.
5. Some prescriptions may require a Preauthorization for purchase through this program. For additional information, the Covered Person should contact the prescription drug program customer service telephone number printed on the back of the EMI Health ID card.
6. Eligible self-administered Injectables are covered under the prescription drug program. Some may be subject to days-supply limits and/or Preauthorization. For additional information, the Covered Person should contact the prescription drug program customer service telephone number printed on the back of the EMI Health ID card.

Note: The prescription card will include only the name of the primary Participant. Dependents eligible for coverage are recorded on a computerized program provided to the pharmacist. Participants that have primary prescription drug coverage with another carrier in addition to this Plan may submit Coordination of Benefits claims for secondary processing. This can be done either by mail using the Express Scripts Coordination of Benefits form located at www.emihealth.com, or electronically by having the pharmacy submit a point-of-sale Coordination of Benefits claim to Express Scripts.

Prescription Claims Review

If EMI Health denies payment of a prescription claim which a Covered Person believes is properly compensable under the applicable terms of the Plan, He shall follow the steps outlined in the "Claims Review Process" section.

HOME DELIVERY PHARMACY SERVICE PROGRAM

Covered Persons may be able to save money by purchasing their maintenance prescriptions through the home delivery pharmacy service (mail order) program.

The home delivery pharmacy service program is separate from the medical plans outlined in this document. Coinsurance and Copayments for prescriptions may not apply toward the medical plan Deductible or Out-of-Pocket Maximum.

A maximum of six vials of insulin per mail order Copayment is allowed. When necessary, additional vials may be purchased during a 90-day period by paying an additional Copayment.

How to Use the Home Delivery Pharmacy Service Program

1. *New prescriptions*: Ask the physician for a sample medication. If medication is required immediately, but will be taken on an on-going basis, ask the doctor to write two prescriptions: the first, up to a 30-day supply, to be filled at a retail pharmacy; the second, up to a 90-day supply, to be filled through the home delivery pharmacy service program. Send the second prescription along with the order form and the appropriate Copayment to the participating home delivery pharmacy service Provider.
2. *Prescriptions currently being taken*: Obtain a new, written prescription, for up to a 90-day supply (plus refills if applicable), from the physician. (In most cases, one can be obtained by calling the physician's office.) Send the new prescription along with the order form and the appropriate Copayment to the home delivery pharmacy service Provider.
3. Important: Sign the order, indicating that the prescribed drugs are for the Covered Person or covered family members. Unsigned orders will be returned unfilled.
4. The participating home delivery pharmacy service will process the order and return it via U.S. Mail or UPS, along with instructions for future refills. Allow up to 14 days for delivery from the time the Covered Person mails the prescription.
5. *Refills*: With the original prescription medication, the Covered Person will receive a notice showing the number of times it may be refilled. Simply mail this refill notice with the Copayment for each prescription in the order envelope provided. Refills should be ordered at least two weeks before they are needed.
6. Some prescriptions may require a Preauthorization for purchase through the home delivery pharmacy service. For additional information, the Covered Person should contact the prescription drug program customer service telephone number printed on the back of the EMI Health ID card.
7. Eligible self-administered Injectables are covered under the home delivery pharmacy service program. Some may be subject to days-supply limits and/or Preauthorization. For additional information, the Covered Person should contact the prescription drug program customer service telephone number printed on the back of the EMI Health ID card.

Note: The prescription card will include only the name of the primary Participant. Dependents eligible for coverage are recorded on a computerized program provided to the pharmacist. Participants that have primary prescription drug coverage with another carrier in addition to this Plan may submit Coordination of Benefits claims for secondary processing. This can be done either by mail using the Express Scripts Coordination of Benefits form located at

www.emihealth.com or electronically by having the pharmacy submit a point-of-sale Coordination of Benefits claim to Express Scripts.

PRESCRIPTION DRUG AND HOME DELIVERY PHARMACY SERVICE EXCLUSIONS

Pharmacy Items Excluded

The following items are excluded under the prescription drug and home delivery pharmacy service (mail order) programs, regardless of medical necessity or prescription by a licensed prescriber:

1. Medication received by a Covered Person before coverage under the Plan is effective or after coverage under the Plan ends.

2. Medication that is not Medically Necessary and appropriate.

3. Fertility medication (Primary or Secondary Infertility).

4. Anorexiants.

5. Chemotherapeutic medications, administered by IV or injections.

6. Medication which is to be taken by, or administered to, an individual, in whole or in part, while He is a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, skilled nursing facility, convalescent Hospital, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

7. Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.

8. Any drug exceeding the number of day's supply or doses eligible in the policy.

9. Charges for the administration of any drug. This exclusion does not apply to covered immunizations administered in a participating pharmacy.

10. Any drugs used for weight loss, and related services, or complications thereof.

11. Progesterone suppositories and related services or complications thereof.

12. Any drug that does not require a prescription except insulin and evidence-based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force. (For guidelines refer to http://bit.ly/USPSTF_AB.)

13. Any over-the-counter drugs even if prescribed by a physician except for evidence-based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force. (For guidelines refer to http://bit.ly/USPSTF_AB.) This exclusion includes but is not limited to, supplements and nutritional substitutes, enteral feedings, amino acids, electrolyte supplements, herbs, and related services.

14. Any drug purchased for Cosmetic purposes, or complications thereof.

15. Any item specifically limited or excluded in the medical exclusions. (See "Medical Plan Exclusions" section.)

16. Any drug for erectile dysfunction.

17. Any drug when it has been determined by the clinical consultants of EMI Health that there is over-utilization of drugs or evidence of drug abuse.

18. Medication amounts in excess of maximum quantity and/or dosage levels indicated by the drug manufacturer and the FDA. Experimental medications, medications for non-approved FDA indications, or non-approved indications as determined by the Plan.

19. Expenses for services in connection with Bioidentical Hormone therapy.

20. Preventive medications including equipment and application of medications, including but not limited to, fluoride, vitamins, minerals, and homeopathic medicine. This exclusion does not include prenatal vitamins prescribed by a physician during pregnancy or those that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force. (For guidelines refer to http://bit.ly/USPSTF_AB.)

21. Non-self-administered Injectables.

22. Any drug when it has been determined that the authorization criteria of the Plan have not been satisfied.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a medical condition.

EMI HEALTH CHOICE DENTAL PLAN BENEFITS

Diagnostic/Preventive Benefits

- Oral examinations two times per Calendar Year
- X-rays are covered as follows:
  - Full mouth – once every three years
  - Supplementary bitewings – up to four procedures, twice per Calendar Year
  - Supplementary periapical – six procedures per Calendar Year
- Cleaning and scaling teeth (prophylaxis) two times per Calendar Year
- Application of fluoride in conjunction with cleaning two times per Calendar Year, limited to Eligible Dependent children up to the 16th birthday

Space Maintainers

- Space maintainers used to maintain the present position of a tooth following an extraction for Eligible Dependent children up to the 16th birthday

Sealants

- Sealants for Eligible Dependent children up to the 16th birthday

Basic Services

- Restoration of decayed teeth with amalgam, synthetics, or plastic, up to one restoration per surface. Repairs to restorations are allowed only once every 18 months, regardless of the reason. Tooth preparation, temporary restorations, cement bases, impressions, and local anesthesia are all considered part of the restoration and are covered only when included in the charge for the entire process.

Major Services

- Gold onlays and crowns are covered if teeth cannot be restored with amalgam, synthetic, porcelain, or plastic. Benefits are payable once every five years for the same tooth.

Endodontic Services

- Endodontic treatment, including root canal therapy. One pulp cap per tooth is allowed. Bases are not covered.

Periodontic Services

- Periodontic services are limited to one perio maintenance (two per calendar year in lieu of preventive cleaning); root scaling and planing (once per quadrant of mouth in any 24 month period); gingivectomy, gingival curettage; osseous surgery including flap entry and closure; pedical or free soft tissue grafts; full mouth debridement (one every five years).

Prosthodontic Services

- Initial installation of a removable or fixed partial or complete denture once every five years. Fixed bridges for patients under age 16 are covered up to the amount allowed for a removable partial denture.

- One laboratory reline is covered following the initial installation of a denture and once every three years thereafter. Office relines are not a covered benefit.
- Implants are covered. Crowns associated with implants fall under the benefit for crowns and are subject to any limits applicable to that benefit.
- Replacement of missing teeth with complete or partial dentures, fixed bridges, or implants is covered.
- Replacement of a denture or implant that is no longer serviceable is covered once every five years.

Oral Surgery Services

- Extractions and other oral surgery involving procedures for simple and complicated extractions of impacted or erupted teeth, including frenectomy, alveolectomy, removal of palatal and mandibular tori, and crown exposure. Post-operative care and removal of sutures are considered part of the surgical procedure and are covered only when included in the charge for the entire surgical procedure.

Anesthesia Services

- General anesthesia, including intravenous sedation, is limited to age seven and under, once per Calendar Year. General anesthesia for the extraction of impacted teeth for individuals age eight and over is covered to the Table of Allowances, based on necessity, not for anxiety management.

Orthodontic Services

Orthodontic services are covered for functionally related problems, not for Cosmetic purposes, for eligible unmarried Eligible Dependent children ages seven through 18.

- Initial diagnostic records (study models, facial photographs, etc.) are covered only if eligible orthodontic treatment is rendered.

- Orthodontic treatment, including diagnostic procedures, X-rays, and appliance therapy.

- Amounts paid under a previous dental care plan for a case in progress, which is defined as the placement of bands, will be deducted from the maximum amount payable for orthodontic benefits under this Plan.

Alternate Treatment

Many dental conditions can be treated in more than one way. This Plan has an alternate treatment clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient receives a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

Benefit Accumulations

All Deductibles, benefit limits, etc., except for the Lifetime Maximum Benefit, accumulate on a Calendar Year basis. All annual maximums are combined for a total of $2,000.00. Eligible Expenses in connection with treatment received from any provider (Advantage Plus, Premier, and Out-of-Network) are combined for the first $1,500.00 each year. Once annual benefits exceed $1,500.00, only Eligible Expenses received from Advantage Plus Dentists will be considered. There will be no additional benefit for Premier or Out-of-Network Dentists.

CHOICE DENTAL PLAN EXCLUSIONS

Notwithstanding anything else in the Plan to the contrary, the items listed below are not covered by the Plan.

EMI Health Choice Dental Plan does not pay for any of the following:

1. Services received by a Covered Person before coverage under the Plan became effective or after coverage under the Plan has terminated.

2. Expenses for preparing dental reports, itemized bills, or claim forms.

3. Illness or injury caused by the negligent or wrongful act of another, or for which the Covered Person is covered by any workers' compensation or similar law; except that EMI Health may advance benefits to or on behalf of the Covered Person in such situations, subject to EMI Health's right of Subrogation and reimbursement set forth herein.

4. Illness or injury that a Covered Person incurred either (1) while in the service of an employer that was obligated by law to provide workers' compensation insurance that would have covered such illness or injury, or, (2) while in the service of an employer that had elected to exclude workers' compensation coverage for such Covered Person, except that EMI Health may elect to advance benefits to or on behalf of the Covered Person in either situation, subject to EMI Health's rights of Subrogation and reimbursement set forth herein.

5. Illness or injury for which the Covered Person is covered by other responsible insurance including, but not limited to, coverage under a government sponsored health plan, except as otherwise provided herein, or as otherwise provided by law.

6. Charges for services related to birth defects or cosmetic surgery or dentistry for solely Cosmetic reasons including, but not limited to, bonding and veneers.

7. Any procedure started prior to the date the patient became covered for such services under this policy. This Exclusion does not apply to covered orthodontic benefits for a case in progress.

8. Medical care, confinement, treatment, services, use of facilities, or supplies for which charges are made by a facility, including freestanding nursing home, rest home, or similar establishment.

9. Plaque control programs, oral hygiene instruction, and dietary instruction.

10. Myofunctional therapy.

11. Lab costs for an oral tissue biopsy.

12. Treatment to correct problems with the way teeth meet or to adjust bite (alter vertical dimensions or restore or equilibrate occlusion) except as covered under orthodontia.

13. Care, treatment, operations, supplies, appliances, aids, devices, or drugs that are not FDA approved.

14. Any loss caused, or contributed to, by the Covered Person committing, or attempting to commit, an Act of Aggression or an illegal act. This exclusion does not apply to benefits for victims of domestic violence or for Covered Persons with mental health conditions.

15. Care, treatment, operations, or supplies that are illegal, Experimental, Investigational, or for research purposes by the United States medical profession that are not recognized or proven to be effective for treatment of illness or injury in accordance with generally accepted dental/medical practices.

16. Expenses in connection with transportation or mileage reimbursement.

17. Expenses including, but not limited to, air fare, meals, accommodations, and car rental.

18. Medications labeled "Caution, Limited by Federal Law to Investigational Use" or experimental drugs. Twelve months must have passed after FDA approval, before the Plan will consider coverage.

19. Services that are not Medically Necessary or Cosmetic services including veneers, special techniques, precious metals used for removable appliances other than orthodontics, precision attachments for partial dentures or bridges, and personal characterization.

20. Any procedure or appliance to correct or treat temporomandibular joint dysfunction (TMJ).

21. Transplants, reimplantations, and associated appliances or services rendered in conjunction with Cosmetic implants. This exclusion does not apply to otherwise covered crowns.

22. Hospital services.

23. Habit-breaking devices or appliances to correct thumb sucking, tongue thrusting, etc.

24. Temporary restorations, appliances, or procedures of any nature, except that temporary restorations are covered when included in the charge for the restoration process.

25. Replacement of lost, stolen, or damaged dentures, except once every five years.

26. Procedures, appliances, or restorations, other than those for replacement of structure loss from caries, that are necessary to alter, restore, or maintain occlusion by any of the following: realignment of teeth, periodontal splinting, gnathological recordings, equilibration, treatment of disturbances of the temporomandibular joint (TMJ), orthognathic procedures.

27. Hypnosis and related analgesia.

28. Restorative dental services in connection with an overdenture.

29. Expenses for services required due to complications associated with, or due to, non-covered services, and where applicable, reversal of non-covered services.

30. Services rendered by anyone other than a licensed Dentist and when necessary and customary, as determined by the standards of generally accepted dental practice.

31. Services for injury resulting from war or any act of war, whether declared or undeclared.

32. Care, treatment, or services the Covered Person is not, in the absence of this policy, legally obligated to pay, except as otherwise provided by law.

33. Care, treatment, or services rendered by any Provider who ordinarily resides in the same household (e.g. Spouse, parent).

34. Benefits for services or treatments covered under any medical plan.

35. Expenses for appointments scheduled but not kept, or for telephone consultations.

36. Expenses for shipping, handling, postage, sales tax, interest, or finance charges.

37. Charges for completion or submission of insurance forms.

38. Prescription drugs and over-the-counter medication.

39. Charges for care, treatment, or surgical procedures that are unnecessary or in excess of the Summary of Benefits or the Table of Allowance.

40. The application of a dental sealant on any tooth that has been previously treated with a temporary or permanent restoration.

41. The application of dental sealants on all Anterior teeth whether Deciduous or permanent teeth.

42. Chemotherapeutic injections.

43. All other services not specified as covered benefits or not specifically included in the contract with the employer, including but not limited to, procedures not listed on the current dental fee schedule.

44. Charges for dental or orthodontic appliances, supplies, medication, or lab tests that are purchased via the internet from Non-participating Providers or vendors, or for which a prescription or physician order is not required.

45. Care, supplies, or services received outside of the United States or from a non U.S. Provider.

EMI HEALTH VSP VISION PLAN BENEFITS

Vision Examination
A vision examination is covered once Service Year. Vision examinations include an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

Prescribed Lenses and Frames
Two prescribed lenses are covered once every Service Year. Frames are covered once every Service Year.

Benefits for lenses and frames include the following directly related Provider services:

- Prescribing and ordering proper lenses
- Assisting in the selection of frames
- Verifying the accuracy of the finished lenses
- Proper fitting and adjustment of frames
- Subsequent adjustments to frames to maintain comfort and efficiency
- Progress or follow-up care as necessary

Contact Lenses
Contact lenses used to correct vision are covered once per person every Service Year in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for one Service Year.

Benefit Maximums
The benefits provided under this Plan are subject to the maximums outlined on the "Summary of Benefits" chart.

Medically Necessary
All benefits will be paid as set forth in the "Summary of Benefits" chart, subject to the Plan provisions. The Plan, regardless of benefits specified, will reimburse or pay any claim only if the services rendered are determined to be Medically Necessary and appropriate. Determination of Medical Necessity and appropriateness will be made by VSP using its own set of criteria, or by an independent contractor appointed by VSP.

Coinsurance Payments
The Plan will pay Eligible Expenses, less any applicable Copayments, Coinsurance payments, or Deductibles, as defined in this Plan and shown on the "Summary of Benefits" chart. Where Copayments, Coinsurance payments, or Deductibles are required for certain Plan Benefits, those payments shall be the personal responsibility of the Covered Person receiving the care and must be paid to the Provider at the time services are rendered.

Discounts, per diem, global fees, or any other arrangements entered into by EMI Health with Providers of services or products will not affect the Coinsurance payment responsibility of the Covered Person.

Obtaining Services from Participating Providers

Benefit Authorization must be obtained prior to receiving Plan benefits from a Participating Provider. When a Covered Person seeks Plan Benefits from a Participating Provider, the Covered Person must schedule an appointment and identify himself as a Covered Person so the Participating Provider can obtain Benefit Authorization from VSP. Each Benefit Authorization will contain an expiration date, stating a specific time period for the Covered Person to obtain Plan Benefits. VSP will issue Benefit Authorizations in accordance with the latest eligibility information furnished by the Plan Sponsor and the Covered Person's past service utilization, if any. Any Benefit Authorization so issued by VSP constitutes a certification to the Participating Provider that payment will be made, irrespective of a later loss of eligibility of the Covered Person, provided Plan Benefits are received prior to the Benefit Authorization expiration date.

Should the Covered Person receive Plan Benefits from a Participating Provider without such Benefit Authorization, then for the purposes of those Plan Benefits provided to the Covered Person, the Participating Provider will be considered a Non-participating Provider, and the benefits available under this Plan will be limited to those for a Non-participating Provider, if any.

Although benefits under the Plan are generally greater for services provided by Participating Providers, the choice to use a Participating Provider or Non-participating Provider is entirely up to the Covered Person. EMI Health does not employ Participating Providers, and they are not agents or partners of EMI Health. Providers participate in the network only as independent contractors. Participating Provider status is not an endorsement or representation by the Plan Sponsor, EMI Health, or VSP as to the qualifications (or quality of care) of any particular Provider.

Emergency Vision Care

When vision care is necessary for Emergency Conditions, Covered Persons may obtain Plan Benefits by contacting a Participating or Non-participating Provider. No prior approval from the Plan is required for Covered Persons to obtain vision care for Emergency Conditions of a medical nature. This Plan does not cover medical services. Covered Persons should contact a physician under their medical insurance plans for care. For Emergency Conditions of a non-medical nature, such as lost, broken, or stolen glasses, the Covered Person should contact EMI Health's customer service department for assistance.

Benefit Accumulations

All Deductibles, benefit limits, etc. accumulate on a Service Year basis.

VSP VISION PLAN EXCLUSIONS

Notwithstanding anything else in the Plan to the contrary, the items listed below are not covered in the Plan. Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame availability from the VSP customer care department at 800-877-7195.

The Plan does not pay for any of the following:

1. Expenses for preparing vision reports, itemized bills, or claim forms.

2. Diagnostic services, other than those provided as a component of a vision examination.

3. Drugs or medications not administered for the purpose of a vision examination.

4. Services, procedures, or supplies determined by the Plan to be special or unusual including, but not limited to, orthoptics, vision training, and low vision aids.

5. Charges for non-prescription sunglasses or other special purpose non-prescribed vision aids.

6. Charges for duplicate or spare eyeglasses, lenses, frames, or contact lenses, even to replace lost, broken, or stolen lenses, frames, or contact lenses.

7. Cosmetic materials. If the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

    - Optional cosmetic processes
    - Anti-reflective coating
    - Color coating
    - Mirror coating
    - Scratch coating
    - Blended lenses
    - Cosmetic lenses
    - Laminated lenses
    - Oversize lenses
    - Polycarbonate lenses
    - Photochromic lenses, tinted lenses (except Pink #1 and Pink #2)
    - Progressive multifocal lenses
    - Ultraviolet (UV) protected lenses
    - Certain limitations on low vision care
    - A frame that costs more than the Plan allowance
    - Contact lenses, except as noted elsewhere herein

8. Eligible Expenses incurred before coverage under this Plan begins or that extend after coverage under this Plan ends.

9. Medical or surgical treatment, care, services, or procedures.

10. Care, treatment, procedures or supplies that are Experimental, as defined in the Plan, or for complications thereof.

11. Services or materials not specified as covered. There is no presumption of coverage.

12. Care, supplies, treatment, and/or services that are not payable under the Plan due to application of any maximum or limit or because the billed charges are in excess of the Maximum Allowable Charge, or are for services not deemed to be reasonable or Medically Necessary and appropriate, based upon the Plan's determination as set forth by and within the terms of this Plan.

COBRA Continuation of Coverage Requirements

Under the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), a Covered Person who could otherwise lose coverage as a result of a "qualifying event" is entitled to elect to purchase medical continuation under the Plan. The coverage will be identical to the coverage provided to Covered Persons to whom a qualifying event has not occurred.

- Qualifying Event. A "qualifying event" is any of the following:

  - For a Participant, termination of employment (other than for gross misconduct) or reduction of hours worked so as to render the employee ineligible for coverage;
  - For a Spouse and Eligible Dependents, death of the Participant;
  - For a Spouse, divorce or legal separation;
  - For a Spouse and Eligible Dependents, loss of coverage due to the Participant becoming eligible for Medicare;
  - For a Dependent child, ceasing to qualify as an Eligible Dependent under the Plan;
  - For Eligible Retirees and their Eligible Dependents, employer bankruptcy under Chapter 11.

See COBRA Administrator for further details.

COORDINATION OF BENEFITS WITH OTHER GROUP PLANS

When a Covered Person is covered by this Plan and another COB Plan, one plan is designated as the Primary Plan. The Primary Plan pays first and ignores benefits payable under the other plan. The Secondary Plan reduces its benefits by those payable under the Primary Plan. If a person has a Health Savings Account (HSA) in conjunction with a high-deductible plan, federal rules may prohibit him or her from having other health coverage that is not a high-deductible plan.

Any COB Plan that does not contain a Coordination of Benefits provision that is consistent with Nevada Revised Statutes (NRS) 689B.064 (Non-conforming Plan) will be considered primary, unless the provisions of both plans state that the Conforming Plan is primary.

If a person is covered by two or more COB Plans that have Coordination of Benefits provisions, each plan determines its order of benefits using NRS 689B.064.

A COB Plan that does not include a Coordination of Benefits provision may not take the benefits of another COB Plan into account when it determines its benefits.

When this Plan is secondary, EMI Health will calculate the benefits the Plan would have paid on the claim in the absence of other health care coverage and apply that amount to any Allowable Expense under the Plan that is unpaid by the Primary Plan. Payment will be reduced so that when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all COB Plans for the claim do not exceed 100 percent of the Allowable Expense for that claim.

This COB Plan will coordinate its benefits with a COB Plan that states it is “excess” or “always secondary” or that uses order of benefits determination rules that are inconsistent with those contained in this rule on the following basis:

- If this Plan is the Primary Plan, EMI Health will pay or provide its benefits on a primary basis;

- If this Plan is the Secondary Plan, EMI Health will pay or provide its benefits first, but the amount of the benefits payable will be determined as if it were the Secondary Plan. Such payment shall be the limit of EMI Health’s liability, and if the other COB Plan does not provide the information needed by EMI Health to determine its benefits within a reasonable time after it is requested to do so, EMI Health will assume that the benefits of the other plan are identical to this Plan, and will pay its benefits accordingly. However, if within three years of payment, EMI Health receives information as to the actual benefits of the Non-conforming Plan, the Plan will adjust any payments accordingly.

- If the Non-conforming Plan reduces its benefits so that the Covered Person receives less in benefits than he or she would have received had EMI Health paid or provided its benefits as the secondary COB Plan and the Non-conforming Plan paid or provided its benefits as the primary COB Plan, then EMI Health shall advance to or on behalf of the Covered Person an amount equal to such difference.

    - In no event will EMI Health advance more than it would have paid had it been the primary COB Plan, less any amount it previously paid.

- In consideration of such advance, EMI Health shall be subrogated to all rights of the Covered Person against the Non-conforming Plan in the absence of Subrogation.

- If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the Primary Plan.

Whenever payments that should have been made under this Plan have been made under any other COB Plan, the Plan Sponsor or EMI Health may, at its own discretion, pay any amounts to the organization that has made excess payments to satisfy the intent of this provision. Amounts paid will be regarded as benefit payment, and the Plan Sponsor and EMI Health will be fully discharged from liability under this Plan to the extent of the payment.

It is important for the Covered Person to take responsibility in reporting to EMI Health any changes in the status of other insurance coverage. Failure to report additional insurance coverage may result in a delay of claims payment.

For prompt reimbursement after the payment from the primary insurance carrier, a copy of the itemized billing and a copy of the explanation of benefits provided by the primary insurance carrier must be included.

The amount of medical benefits paid by group, group-type, and individual automobile "no-fault" medical payment contracts are not payable under this Plan. However, when all available no-fault auto medical insurance benefits have been paid, this Plan will pay according to its normal schedule of benefits. If the Covered Person does not have proper no-fault insurance and is involved in an Accident, no benefits will be paid under this Plan until the minimum no-fault auto medical benefits have been paid by the Covered Person, his dependent, or a third party.

Certain facts may be needed in order to apply COB rules. These facts may be obtained from, or provided to, any other organization or person, subject to applicable privacy laws. Each person claiming benefits under this Plan will be required to give the Plan Sponsor and EMI Health any facts needed to pay a claim.

CLAIMS PROCEDURE

Proof of Loss

Except as otherwise provided in this Plan or by Nevada law, no benefits provided under this Plan shall be paid to, or on behalf of, a Covered Person unless the Covered Person, or his authorized representative, has first submitted a written or Electronic Data Interchange (EDI) claim for benefits to EMI Health, on behalf of Plan Sponsor. Claims may be submitted at any time within 12 months of the date the expenses are incurred. If, however, the Covered Person shows that it was not reasonably possible to submit the claim within that time period, then a claim may be submitted as soon as reasonably possible. The Plan may deny an untimely claim.

How to File a Medical or Dental Claim

Submit properly completed and coded Provider bills (e.g., HCFA 1500) to the following address:

EMI Health
5101 S. Commerce Dr.
Murray, Utah 84107

If the claim form is not properly completed, it cannot be processed, and it will be returned.

How to File a Vision Claim

If Non-participating Provider coverage is indicated in the Summary of Benefits, written proof (receipt and the Covered Person's identification information) of all claims for services received from Non-participating Providers shall be submitted by Covered Persons to the following address within 365 days of the date of service. Covered Persons also may be required to submit claims for Participating Providers in compliance with this section. VSP may reject such claims filed more than 365 days after the date of service:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Failure to submit a claim within this time period, however, shall not invalidate or reduce the claim, if it was not reasonably possible to submit the claim within such time period, provided the claim was submitted as soon as reasonably possible. Failure to give notice or file proof of loss as required does not bar recovery under this Plan, if the insurer fails to show it was prejudiced by the failure.

Requests for Additional Information

There are times when claims submitted in the Covered Person's behalf may not contain sufficient information for EMI Health to process them correctly. In those situations, EMI Health will request additional information from the Covered Person or the Provider. EMI Health is likely to request information directly from the Covered Person for the following reasons:

- To obtain details of an Accident
- To expedite coordination of benefits
- To conduct an audit

Covered Persons can expedite the processing of their claims by providing the requested information as quickly as possible, and in as much detail as possible.

Claims Audits

In addition to the Plan's medical record review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed Eligible Expenses and/or are not Medically Necessary and reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of Eligible Expenses or other applicable provisions, as outlined in this Plan Document.

The Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accordance with the terms of this Plan Document.

Exhaustion of Administrative Remedies

No action at law or in equity may be brought against the Plan Sponsor, EMI Health, or the Plan Administrator, until the Covered Person has exhausted the Claims Review Process, as provided in this Plan.

Appointment of Authorized Representative

The Covered Person may appoint an authorized representative to act on his behalf in pursuing a benefit claim or appealing an Adverse Benefit Determination. The Covered Person shall appoint the authorized representative by signing an "Appointment of Authorized Representative" form available from EMI Health, with the authorized representative accepting such appointment by signing the Appointment of Authorized Representative; provided, however, that, in the case of a claim involving an Urgent Preauthorization Request, as defined in this Plan, a "Provider" as defined by this Plan, with knowledge of the Covered Person's medical condition shall be permitted to act as the authorized representative of the Covered Person. The Covered Person desiring to appoint an authorized representative shall submit the fully executed form to the Plan Administrator.

Medical and Dental Claims Review Process

If EMI Health denies payment of a Post-service Health or prescription claim (an Adverse Benefit Determination) which a Covered Person believes is properly compensable under the applicable terms of the Plan, the Covered Person shall within the time limits provided in subparagraphs one through five below after receipt of notice of the Adverse Benefit Determination appeal the denial. The Plan provides three levels of appeal review, which may be performed either internally or independently, as described herein. The first two levels are required levels that must be exhausted before the Covered Person may file suit in court. The third level is a voluntary level. A Covered Person may submit comments, documents, records, and other information relating to the claim, and will upon request, be provided free of charge, access to, and copies of, all documents, records, and other information relevant to the claim that were used in the initial benefit determination.

Review of first and second level appeals of Adverse Benefit Determination, except those described in the following paragraph, will be conducted internally by a person or a committee of persons who is neither the individual who made the initial Adverse Benefit Determination, nor the subordinate of that individual. If agreement is not reached on the claim, the Covered Person shall within the time limits provided in subparagraphs one through five below after the decision of the first level have the right to request a second level appeal regarding the Adverse Benefit Determination. This request must be in writing and must be received by EMI Health, on behalf of Plan Sponsor, within the time limits provided in subparagraphs one through five below after receipt of notice indicating the decision of the first level. The outcome of the second level review shall be reported, with all appropriate documentation, to Plan Administrator's Board of Trustees, who shall have final authority over the decision. If the Covered Person disagrees with the decision of the second level review, the Covered Person shall have a right to pursue any remedies available at law or equity.

Independent External Review for First and Second Level Appeals

If the appeal of an Adverse Benefit Determination is based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, an independent review will be conducted. For this review, the Plan will consult with an independent health care professional,

who is not affiliated with EMI Health, or the Plan Sponsor, who was not involved in the initial benefit determination, and who has appropriate training and expertise in the field of medicine involved in the medical judgement. There will be no fee charged to the Covered Person for an independent review.

The following time limits shall apply to Post-service Health Claims:

(1) EMI Health will provide a notice of its initial claim decision within (a) 30 days after receiving the initial claim, or (b) 45 days after receiving the claim if EMI Health determines that an extension is necessary due to matters beyond the control of the Plan and if EMI Health provides an extension notice during the initial 30-day period. If the extension is due to the Covered Person's failure to submit sufficient information necessary to decide a claim, the extension notice shall specify the additional required information and the Covered Person will have at least 45 days to provide the additional information. The period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent until the date on which the Covered Person provides the additional required information.

(2) If EMI Health denies the claim in whole or in part, the Covered Person has 180 days after receiving notice of the claim denial to appeal the decision in writing.

(3) EMI Health will provide notice of its decision on appeal within 30 days after receiving the request for appeal.

(4) If the Claims Review Committee denies the claim in whole or in part on appeal, the Covered Person has 60 days after receiving notice of the denial to request a second level appeal in writing.

(5) EMI Health shall report the outcome of the second level appeal with all appropriate documentation to Plan Administrator's Board of Trustees as soon as possible after making the decision and will provide notice of its decision on the second level of appeal to the Covered Person within 30 days after receiving the notice of appeal.

Third Level Independent Review

If after exhaustion of the claims review process provided in this Plan, the Covered Person still disputes a determination of Medical Necessity, appropriateness, healthcare setting, level of care, or effectiveness of the healthcare service or treatment, the Covered Person shall have the voluntary option to submit the Adverse Benefit Determination for an independent review. Requests for review must be submitted to the Plan within 120 days after the receipt of a notice of an Adverse Benefit Determination. The independent review decision is binding on the Plan and the Covered Person, except to the extent that other remedies are available under federal or state law.

Standard Independent Review

1. Within five business days following receipt of the request, the Plan will determine eligibility, and within one day of completing the eligibility review will notify the Covered Person in writing whether the request is complete and if it is eligible for independent review.

2. If the request is not complete, the Plan will inform the Covered Person in writing what information or materials are needed to make the request complete.
3. If the request is not eligible for independent review, the Plan will inform the Covered Person in writing the reasons for ineligibility.
4. If the request is eligible for independent review, the Plan shall assign an independent review organization. Within five business days, the Plan will provide to the assigned independent review organization the documents and any information considered in making the Adverse Benefit Determination.
5. The Covered Person may submit additional information to the independent review organization within 10 business days. The independent review organization will forward to the Plan, within one business day of receipt, any information submitted by the Covered Person.
6. Within 45 calendar days after receipt of the request for an independent review, the independent review organization shall provide written notice of its decision to the Covered Person and the Plan.
7. Upon receipt of a notice reversing the Adverse Benefit Determination, the Plan shall within one business day approve the coverage that was the subject of the Adverse Benefit Determination.

Expedited Independent Review

1. An expedited independent review shall be available if the Adverse Benefit Determination meets any of the following conditions:
   - involves a medical condition which would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function;
   - in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Adverse Benefit Determination; or
   - concerns an admission, availability of care, continued stay or healthcare service for which the insured received emergency services, but has not been discharged from a facility.
2. Upon receipt of the request, the Plan will immediately determine eligibility and notify the Covered Person in writing whether the request is complete and if it is eligible for independent review.
3. If the request is not complete, the Plan will inform the Covered Person in writing what information or materials are needed to make the request complete.
4. If the request is not eligible for independent review, the Plan will inform and the Covered Person in writing the reasons for ineligibility.
5. If the request is eligible for independent review, the Plan will immediately assign an independent review organization. Within one business day, the Plan will provide to the assigned independent review organization the documents and any information considered in making the Adverse Benefit Determination.
6. The Covered Person may submit additional information to the independent review organization within one business day. The independent review organization will forward to the Plan, within one business day of receipt, any information submitted by the Covered Person.
7. The independent review organization shall as soon as possible, but no later than 72 hours after receipt of the request for an expedited independent review, make a decision and

notify the Plan and the Covered Person, of that decision. If notice of the decision is not in writing, the independent review organization shall provide written confirmation of its decision within 48 hours after the date of the notification of the decision.

8. Upon receipt of a notice reversing the Adverse Benefit Determination, the Plan shall within one business day approve the coverage that was the subject of the Adverse Benefit Determination.

Independent Review of Experimental or Investigational Service or Treatment

1. A request for an independent review based on experimental or investigational service or treatment shall be submitted with certification of the following from the physician:
   - Standard healthcare service or treatment has not been effective in improving the Covered Person's condition;
   - Standard healthcare or treatment is not medically appropriate for the Covered Person; or
   - There is no available standard healthcare service or treatment covered by the Plan that is more beneficial than the recommended or requested healthcare service or treatment.
2. Within five business days (or one business day for an expedited review) following receipt of the request, the Plan will determine eligibility, and within one day of completing the eligibility review will notify the Covered Person in writing whether the request is complete and if it is eligible for independent review.
3. If the request is not complete, the Plan will inform the Covered Person in writing what information or materials are needed to make the request complete.
4. If the request is not eligible for independent review, the Plan will inform the Covered Person in writing the reasons for ineligibility.
5. If the request is eligible for independent review, the Plan shall assign an independent review organization. Within five business days (one business day for an expedited review), the Plan will provide to the assigned independent review organization the documents and any information considered in making the Adverse Benefit Determination.
6. The Covered Person may submit additional information to the independent review organization within 10 business days (one business day for an expedited review). The independent review organization will forward to the Plan, within one business day of receipt, any information submitted by the Covered Person.
7. Within one business day after receipt of the request, the independent review organization shall select one or more clinical reviewers to conduct the review. The clinical reviewers shall provide to the independent review organization a written opinion within 20 calendar days (five calendar days for an expedited review).
8. Within 20 calendar days (48 hours for an expedited review) after receipt of the clinical reviewer's opinion, the independent review organization shall provide notice of its decision to the Covered Person and the Plan.
9. Upon receipt of a notice reversing the Adverse Benefit Determination, the Plan shall within one business day approve the coverage that was the subject of the Adverse Benefit Determination.

Vison Claims Review Process

If the Plan denies payment of a claim (an Adverse Benefit Determination), which a Covered Person believes is properly compensable under the applicable terms of the Plan, the Covered Person or his authorized representative may submit a request to VSP at PO Box 997105, Sacramento CA 95899-7105, for a full review of the denial. Covered Persons may designate any

person, including the Provider, as an authorized representative. References to Covered Person in this section include the Covered Person's authorized representative, where applicable.

1. **Initial Appeal:** The request must be made within 180 days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied, including the Participant's name, the Member ID number, the Covered Person's name and date of birth, the Provider of services, and the claim number. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision shall be communicated to the Covered Person within 30 calendar days after receipt of a request for an appeal from the Covered Person.

2. **Second Level Appeal:** If the Covered Person disagrees with the response to the initial appeal of the claim, the Covered Person has a right to a second level appeal. Within 60 calendar days after receipt of VSP's response to the initial appeal, the Covered Person may submit a second appeal to VSP, along with any pertinent documentation. VSP shall communicate its final determination to the Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies

When the Covered Person has completed the appeals process stated herein, additional voluntary dispute resolution options may be available, including mediation. The Covered Person may contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally under the provisions of ERISA, the Covered Person has the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and the Covered Person disagrees with the outcome.

Subrogation and Reimbursement

When the Plan Sponsor has advanced payment of benefits to or on behalf of a Covered Person for any bodily injury actionable at law or for which the Covered Person may obtain a recovery from a third party or any other responsible insurance, the Plan acquires a right of Subrogation against the third party, or other responsible insurance, and a right of reimbursement against the Covered Person. In such situations, the Covered Person has the following obligations:

- The Covered Person must reimburse the Plan, up to the amount of such benefits advanced or paid by the Plan, as follows: (a) out of any recovery obtained by the Covered Person from the third party (or such party's liability insurance) by judgment, settlement, or otherwise, whether or not the Covered Person is or has been made whole. The Plan is entitled to the first dollar of any recovery by the Covered Person and each dollar thereafter up to the amount of benefits advanced or paid by the Plan for the injuries to the Covered Person that were caused by the third party; and (b) out of every recovery obtained by the Covered Person from his or her underinsured or uninsured motorist coverage. The Covered Person shall do nothing to prejudice the rights of EMI Health.

- The Covered Person cannot limit or avoid such reimbursement obligation to the Plan by any agreement with the third party or any assignment or designation of such proceeds.

- The Covered Person must not release or discharge any claims that the Covered Person may have against any potentially responsible parties or insurance without written permission from the Plan.

- The Covered Person must fully cooperate and assist with the Plan Sponsor and EMI Health (including, but not limited to, executing all required instruments and papers), if the Plan chooses to pursue its own right of Subrogation against the third party; the Plan's right of Subrogation is limited to the amount of benefits advanced or paid by the Plan to or on behalf of the Covered Person as a result of the fault of the third party, and the Plan's right to recover such benefits from the third party does not depend upon whether the Covered Person is made whole by any recovery. This right of reimbursement shall remain in effect until the Plan is repaid in full. The Plan Sponsor and EMI Health may also pursue their right of Subrogation against any other responsible insurance of the Covered Person provided the Covered Person has been made whole.

  The benefits under this Plan are secondary to any coverage under no-fault or similar coverage.

  The Plan, by providing benefits hereunder, is hereby granted a lien on the proceeds of any settlement, judgment, or other payment intended for, payable to, or received by the Covered Person, and the Covered Person hereby consents to said lien and agrees to take whatever steps are necessary to help the Plan secure said lien. The Covered Person agrees that said lien shall constitute a charge upon the proceeds of any recovery and the Plan shall be entitled to assert security interest thereon. By the acceptance of benefits under the Plan, the Covered Person agrees to hold the proceeds of any settlement in trust for the benefit of the Plan to the extent of 100 percent of all benefits paid on behalf of the Covered Person.

  By accepting benefits hereunder, the Covered Person, hereby grants a lien and assigns to the Plan an amount equal to the benefits paid against any recovery made by or on behalf of the Covered Person. This assignment is binding on any attorney who represents the Covered Person, whether or not the Covered Person's agent, and on any insurance company or other financially responsible party against whom the Covered Person may have a claim provided said attorney, insurance carriers, or others have been notified by the Plan or its agents.

  In the event the Covered Person fails to reimburse the Plan Sponsor and/or EMI Health for advanced payment of benefits as provided for in this section, then in addition to reimbursement to Plan Sponsor and/or EMI Health of the advanced payment(s) the Covered Person shall be responsible for all fees and expenses, including but not limited to collection costs, court costs, litigation expenses and attorney's fees, incurred by Plan Sponsor and/or EMI Health for collecting the advanced payment(s).
  Any reference to state law in any other provision of this Plan shall not be applicable to this provision, if the Plan is governed by ERISA.

Right of Recovery

The Plan will have the right to recover any payment made in excess of the Plan's obligations. Such recoveries must be initiated within 12 months (or 24 months for a COB claim) from the date a payment is made unless the recovery is due to fraud or intentional misrepresentation of material fact by the Covered Person. This right of recovery applies to payments made to the Covered Person or to the Provider. If such overpayment is made to the Covered Person, he or

she must promptly refund the amount of the excess. If the overpayment is made to a Provider, and attempts to recover overpayments from said Provider are exhausted, the Covered Person may be responsible for reimbursement to the Plan. The Plan may, at its sole discretion, offset any future benefits against any overpayment.

Accident or ***Accidental Injury,*** for which benefits are provided, means a single unpremeditated event of violent or external means that happens suddenly, is unexpected, and is identifiable as to time and place. Injuries resulting from willful action, including lifting, pushing, pulling, bending, straining, biting, or chewing, are not considered within the definition of accident.

Act of Aggression means any physical contact initiated by the Covered Person that a reasonable person would perceive to be a threat of bodily harm.

Additional Benefits means those limited benefits provided by the Plan that are available only if specific medical criteria, established by EMI Health, on behalf of the Plan Sponsor, are met. The portion the Covered Person pays for these benefits may not apply toward the Out-of-Pocket Maximum.

Adverse Benefit Determination means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A termination of benefits; or
4. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in the Plan.

Allowable Expense, when used in conjunction with Coordination of Benefits, shall have the same meaning as the term "Allowable Expense" in NRS Chapter 689B.

Ancillary Charges, when used in conjunction with Hospital expenses, means services and supplies in excess of daily room and board charges.

Anterior means the teeth and tissues located towards the front of the mouth; maxillary and mandibular incisors and canines.

Benefit Authorization means authorization from VSP identifying the individual named Covered Person and identifying those Plan Benefits to which the Covered Person is entitled.

Calendar Year means the 12-month period beginning January 1 and ending December 31.

Carve-Out Area means the geographic areas of Mesquite and Moapa Valley, Nevada (including without limitation, Overton, Logandale, and Caliente), St. George, Utah and certain other small rural communities in states neighboring to Nevada in which such Participants reside.

CHIP refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

COB Plan means a form of coverage with which Coordination of Benefits is allowed. These COB Plans include the following:

- Individual and group accident and health insurance contracts and subscriber contracts, except those included in the following paragraph
- Uninsured arrangements of group or group-type coverage
- Coverage through closed panel plans
- Medical care components of long-term care contracts, such as skilled nursing care
- Group-type contracts
- Medicare or other governmental benefits, as permitted by law

The term COB Plan does not include any of the following:

- Hospital indemnity coverage benefits or other fixed indemnity coverage
- Accident-only coverage
- Specified disease or specified Accident policies
- Vision and dental benefits, and any other limited benefit health coverage not an integral part of the Plan
- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or a "to and from school" basis
- Benefits provided in long-term care insurance policies for non-medical services
- Any state plan under Medicaid
- A government plan, which by law, provides benefits that are in excess of those of any private insurance or other non-governmental plan
- Medicare supplement policies

The term COB Plan is construed separately with respect to each plan, contract, or other arrangement for benefits or services. The term COB Plan may also mean a portion of a plan, contract, or other arrangement which is subject to a Coordination of Benefits provision, as separate from the portion which is not subject to such a provision.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Administrator means the entity selected by the Plan Sponsor to administer COBRA benefits. See Plan Sponsor for COBRA Administrator contact information.

Coinsurance means the percentage of eligible charges payable by a Covered Person directly to a Provider for covered services. Coinsurance percentages are specified on the "Summary of Benefits" chart.

Complementary and Alternative Medicine means healthcare systems, practices, and products that are not presently considered to be part of conventional medicine.

Confinement or ***Confine*** means an uninterrupted stay following formal admission to a Hospital, skilled nursing facility, or Inpatient rehabilitation facility.

Conforming Plan means a COB Plan that is subject to NRS Chapter 689B.

Coordination of Benefits means a provision establishing an order in which plans pay their Coordination of Benefits claims, and permitting Secondary Plans to reduce their benefits so that the combined benefits of all plans do not exceed total Allowable Expenses.

Copayment or ***Copay*** means, other than Coinsurance, a fixed dollar amount that a Covered Person is responsible to pay directly to a Provider. Copayment amounts are specified on the "Summary of Benefits" chart.

Covered Person means an Eligible Employee or his Eligible Dependent, or Eligible Retiree, who enrolled with the Plan to receive covered services and who is recognized by the Plan as a Covered Person. Employees/retirees of the Plan Sponsor who are eligible to become Covered Persons can choose to enroll dependents who satisfy the Plan's dependent eligibility requirements. In situations requiring consent, payment, or some other action, references to "Covered Person" include the parent or guardian of a minor or disabled Covered Person on behalf of that Covered Person.

Custodial Care means maintenance of a Covered Person beyond the acute phase of Illness or injury. Custodial Care may include rooms, meals, bed, or skilled medical care in a Hospital, facility, or at home. Care is considered custodial when its primary purpose is to meet personal needs. Custodial Care may include, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, eating, taking medication, or bowel or bladder care.

Deciduous means having the property of falling off or shedding; a name used for the primary teeth.

Deductible means the amount paid by a Covered Person for Eligible Expenses from the Covered Person's own money before any benefits will be paid under this Plan.

Domestic Partner means a person who is not related to the Participant by blood, with whom the Participant has established a long-term relationship of indefinite duration, with an exclusive commitment similar to that of marriage. Notwithstanding this definition, in order to qualify for coverage under the Plan, a Domestic Partner must meet the requirements of the *Domestic Partner Eligibility* section.

Durable Medical Equipment means a device that meets all of the following conditions:

- Can withstand repeated use
- Is primarily and customarily used to serve a medical purpose rather than for convenience and/or comfort
- Generally is not useful to a person in the absence of Illness or injury
- Is appropriate for use in the home
- Is Medically Necessary and appropriate

Durable Medical Equipment includes braces, crutches, and rental of special medical equipment such as a wheelchair, Hospital-type bed, or oxygen equipment. Regardless of Medical Necessity, any home, van, or other vehicle modifications, and/or improvements are not covered benefits.

Eligible Dependent means a dependent who satisfies the dependent eligibility requirements as set forth in the THT Plan (found on page 13 at www.teachershealthtrust.org under Participants, Plan Benefits and 2017 Plan Document).

Eligible Employee means an individual residing in the Carve-Out Area who is a licensed employee identified by the CCSD, paid on the teachers' salary schedule, and eligible for representation by the CCEA; or a licensed employee participating in a CCSD Charter School and acting in the capacity of a teacher; or an employee of the CCEA, CTE or Plan Sponsor.

Eligible Expenses means those charges incurred by the Covered Person for Illness or injury that meet all of the following conditions:

- Are necessary for care and treatment and are recommended by a Provider while under the Provider's continuous care and regular attendance.
- When more than one treatment option is available, and one option is no more effective than another, the Eligible Expense shall be for the least costly option that is no less effective than any other option.
- Do not exceed the EMI Health Summary of Benefits and the Maximum Allowable Charge for the services performed or materials furnished.
- Are not excluded from coverage by the terms of this Plan.
- Are incurred during the time the Covered Person is covered by this Plan.

Eligible Retiree means a retiree who satisfies the Plan's eligibility requirements for retirees as set forth in the THT Plan (found on page 152 at www.teachershealthtrust.org under Participants, Plan Benefits and 2017 Plan Document).

Emergency Care means health care services that are provided for a condition of recent onset and sufficient severity including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in any of the following conditions:

- Placing the patient's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

EMI Health means Educators Health Plans Life, Accident, and Health, Inc.

Enrollment Date means the first day of coverage or if there is a waiting period before coverage takes effect, the first day of the waiting period.

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

Exclusion means any charge that is not eligible for payment under this Plan

Experimental or Investigative means medical treatment, services, devices, medications, or other methods of therapy or medical practices, which are the subject of on-going research, Experimental study, or Investigational arm of an on-going clinical trial, or are otherwise under study to determine maximum tolerated treatment, adverse effects, safety, or efficacy as compared with the standard means of diagnosis or treatment.

- These Experimental or Investigative methods are not yet accepted as an approved or standard of care diagnosis or treatment by the U.S. Food and Drug Administration, the American Medical Association, the Surgeon General, or by Reliable Evidence.
- Reliable Evidence may include, but is not limited to, (a) reports from national, evidence-based, medical-review organizations where the reviews are performed by MD consultants who are Board Certified and have expertise in the particular field; (b) evidence-based guidelines from national, professional specialty societies, and (c) published systematic reviews, meta-analyses, and other evidence-based assessments of recent peer-reviewed publications from authoritative, scientific medical journals performed by experts in the field.

Extended Care Facility means an institution, or distinct part thereof, licensed according to state law and operating within the scope of its license.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Former Employee means an employee who has retired or terminated employment and who is eligible for continuation of coverage.

Grace Period means the period that shall be granted for the payment of any policy charge, during which time the policy shall continue in force; however, any claims received for services rendered during the Grace Period, will be held for processing until policy charges are paid in full. In no event shall the Grace Period extend beyond the date the policy terminates.

He or ***Him*** includes and means she or her.

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

Home Health/Skilled Nursing Care means medical care and treatment rendered to a sick or injured Covered Person in the Covered Person's home when the Covered Person is unable to leave his home, is completing treatment that was initiated in the Hospital, and/or care in the final months of life, by a nurse under the written order and general supervision of the Covered Person's physician, when such Home Health/Skilled Nursing Care Providers work within an organization or company licensed by the state to provide such medical care and treatment.

Hospital means a facility that is so licensed and provides diagnostic, therapeutic, and rehabilitative services to both Inpatients and outpatients by, or under the supervision of, physicians.

Illness means a bodily disorder, disease, mental or emotional infirmity, and all Illnesses due to the same or a related cause or causes.

Implant means any FDA approved foreign object or device that is surgically inserted.

Injectable means any fluid drug or medicine introduced into the body (skin, subcutaneous tissue, muscle, blood vessels, or a body cavity) with a sterile syringe for therapeutic benefit.

Inpatient means an individual assigned to a bed in any department of a Hospital, other than an outpatient section, and charged for room and board by the Hospital.

Intensive Care Room means a Hospital section, ward, or wing that operates exclusively for critically ill Covered Persons and provides special supplies, equipment, and constant supervision and care by registered nurses or other highly trained Hospital personnel. Any facility maintained for the purpose of providing normal post-operative recovery treatment is not an Intensive Care Room.

Late Enrollee means a person who enrolls for coverage at any point after his first 31 days of employment, except in the case of Special Enrollment.

Life-threatening Condition means the sudden and acute onset of an injury or illness where any delay in treatment would jeopardize the Covered Person's life or cause permanent damage to his health. Life-threatening Conditions include, but are not limited to, loss of heartbeat, loss of consciousness, convulsions, stopped or severely obstructed breathing, food poisoning, or massive uncontrolled bleeding.

Major Diagnostic Testing, when used in conjunction with a medical procedure or diagnosis, is interpreted according to generally accepted medical practice and definitions. A Major Diagnostic Test is defined as a CT Scan, magnetic resonance imaging (MRI), nuclear medicine (NMR), or covered genetic, molecular, or gene-based testing. This distinction is for the benefit or convenience of the Covered Persons and may change without prior notice to Covered Persons.

Mastectomy means the surgical removal of all or part of a breast.

Maximum Allowable Charge means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of the following:

- The Table of Allowances;
- The Usual and Customary Charge; or
- The actual billed charges for the covered services.

The Plan has the discretionary authority to decide if a charge is Usual and Customary Charge and for a Medically Necessary and reasonable service. The Maximum Allowable Charge will not include payment for any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medical Supplies include, but are not limited to, items such as oxygen or surgical dressings.

Medically Necessary or ***Medical Necessity*** means any health care service, supply, or accommodation the Provider renders for the treatment of Illness or injury that meets all of the following conditions:

- Consistent with the symptoms or diagnosis
- Provided in the most cost-effective setting that can be used safely
- Not for the convenience of a Covered Person, physician, Hospital, or other Provider
- Appropriate with regard to standards of good medical practice in the community and could not be omitted without adversely affecting the condition or quality of medical care, as determined by established medical review

- Within the scope of the Provider's licensure
- Consistent with, and included in, procedures established and recognized by EMI Health or a designated representative

Medicare means the Hospital and Supplementary Insurance Plan established by Title XVIII of the Social Security Act of 1965, as amended.

New Enrollee means a person who enrolls for coverage during his first 31 days of employment or under Special Enrollment rights.

Non-participating Provider means a health care practitioner operating within the scope of his license, i.e., physician, oral surgeon, Dentist, anesthetist, etc., or a facility operating within the scope of its license, who is not a Participating Provider.

Open Enrollment means the period, as defined by the Plan Sponsor, during which an Eligible Employee may apply for insurance coverage for himself or his Eligible Dependents.

Out-of-Pocket Maximum is designed to insure against financial hardship caused by unexpected expenses from catastrophic Illness. The Out-of-Pocket Maximum amount is specified on the "Summary of Benefits" chart. When the Covered Person has satisfied any applicable Deductible and paid Eligible Expenses, including Copayments, up to the Out-of-Pocket Maximum, EMI Health on behalf of Plan Sponsor, will pay remaining Eligible Expenses at 100 percent of the Maximum Allowable Charge, for the remainder of that Calendar Year. The Participating Provider and Non- Participating Provider Options each have a separate Out-of-Pocket Maximum.

Outpatient Services means services rendered at a Hospital or ambulatory Surgical Center to Covered Persons who are not charged for room and board, but receive treatment and return home the same day.

Participant means an Eligible Employee or Eligible Retiree covered under the Plan. Participants are also Covered Persons.

Participating Provider means a health care practitioner operating within the scope of his license, i.e., physician, oral surgeon, dentist, anesthetist, etc., or a facility operating within the scope of its license, who has contracted with the Plan to render covered services and who has otherwise met the criteria and requirements for participation in the Plan. In regards to vision benefits, Participating Provider means those doctors who have agreed to participate in Vision Service Plan (VSP)'s network.

Period of Confinement means the time the Covered Person is confined in a medical facility on an Inpatient basis.

Plan means the Teachers Health Trust Self-funded Health Benefit Plan (Carve-Out Program) (EMI Health Care Plus Medical, Choice Dental, and VSP Vision).

Plan Sponsor means Plan Sponsor as stated in the "General Plan Information" section of this Plan.

Plan Year means the 12-month period beginning each January 1 and ending on the following December 31.

Post-service Health Claim means any claim for a benefit under the Plan that is not a Preauthorization. Post-service Claims are claims that involve only the payment or reimbursement of the cost for medical care that has already been provided.

Preauthorization (Pre-service claim) means the procedure a Provider and/or Covered Person must follow in order to assure the medical necessity and appropriateness of care, as well as benefit eligibility. Preauthorization procedures must be followed in order for a Covered Person to receive the maximum benefits available under this Plan for Inpatient stays and other specified procedures.

Primary Infertility means a person has never been able to conceive a child.

Primary Plan means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration.

Prosthesis means an artificial substitute for a missing body part, such as an arm, leg, or eye, used for functional reasons.

Provider means a health care practitioner operating within the scope of his license, i.e., physician, oral surgeon, dentist, chiropractor, anesthetist, etc. Provider also means a facility operating within the scope of its license.

Reconstructive, Cosmetic, or ***Plastic Surgery*** means any surgery performed primarily to improve physical appearance.

Routine Exam means a hearing, vision, gynecological, or physical exam, including well-baby care, when the physician bills using a preventive diagnosis code rather than a medical diagnosis code.

Scientific Evidence means 1) scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or 2) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Secondary Infertility means a condition where a person has been able to conceive at least once.

Secondary Medical Condition means a complication related to an Exclusion from coverage in the Plan.

Secondary Plan means any plan that is not a Primary Plan.

Service Year means the 12-month period following the receipt of a covered service.

Special Enrollment means the right of an individual to enroll during the Plan Year, rather than waiting for the next Open Enrollment period, if He has experienced a qualifying event (including marriage, divorce, birth, adoption, placement for adoption, loss of other insurance coverage, or relocation of primary residence into Carve-Out Area) under HIPAA or any applicable ERISA regulations. The Participant must complete a new enrollment form and submit it to the Plan Sponsor within 31 days of any change in coverage or status.

Spouse means the person to whom the Participant is lawfully married or the person to whom the Participant is lawfully recognized as a common law Spouse.

Subrogation means the right that the Plan has by virtue of this contract, and also by virtue of common law, to recover from a third party, or other responsible insurance, monies that the Plan has advanced or paid to or on behalf of a Covered Person, where such monies were paid as a result of an injury to the Covered Person that was the fault of the third party.

Summary of Benefits means the outline of benefits as established by the Plan and incorporated by reference herein.

Surgical Center means any facility duly licensed and operating within the scope of its licensure.

Table of Allowances means the schedule for payment of covered services established by EMI Health.

Total Disability or Totally Disabled means the inability of a Participant to perform his regular occupation. Participants are not disabled if they are capable of performing similar duties for the same employer.

Transplant means an organ or tissue taken from the body for grafting into another area of the same body or into another individual. (Not withstanding this definition, refer to the covered Transplant section in the Plan description.)

Urgent Preauthorization Request means a request for Preauthorization (Pre-service Claim) of medical care or treatment, if application of the time periods for making non-urgent care determinations (1) could seriously jeopardize the claimant's life, health, or ability to regain maximum function, or (2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Preauthorization request. The determination of whether a request is an Urgent Preauthorization Request will be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. A request will be treated as an Urgent Preauthorization Request if a physician with knowledge of the claimant's medical condition determines it to be one.

Usual and Customary Charge means the charge identified by the Plan Administrator, taking into consideration 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 a Usual and Customary Charge, fee(s) 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 Plan Administrator will determine whether the charge for a specific procedure, service, or supply is Usual.

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 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 Plan Administrator will determine whether the charge for a specific procedure, service, or supply is Customary.

The term "Usual and Customary Charge" 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.

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.

VSP means Vision Service Plan Insurance Company. VSP is the claims processor for the vision benefits.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

HIPAA NOTICE OF PRIVACY PRACTICES

Participants under the Plan should refer to the HIPAA Notice of Privacy Practices provided under the THT Plan (found on pages 175 to 181 at www.teachershealthtrust.org under Participants, Plan Benefits and 2017 Plan Document).

LIFE INSURANCE BENEFIT

Participants under the Plan are also be eligible for the Life Insurance Benefit provided under the THT Plan (found on pages 135 to 150 at www.teachershealthtrust.org under Participants, Plan Benefits and 2017 Plan Document), administered by Plan Sponsor.

HOSPITAL SUPPLEMENT PLAN

If Participants decide that they do not want medical coverage under the Plan, Participants are eligible for a Hospital Supplement Plan administered by EMI Health. **There is no medical coverage available under the Hospital Supplement Plan.** Instead, this plan pays $260 per day for every day of overnight inpatient hospitalization or each 24 hours of observation for which room and board is charges. This benefit is paid for up to a lifetime maximum of 365 days.

Dental, vision and a $50,000 life insurance benefit are included as a package in the Hospital Supplement Plan.

The Hospital Supplement Plan does not coordinate with any other plan and is NOT AVAILABLE TO DEPENDENTS.

Your claim must be submitted no later than twelve months following the date of your Hospital discharge. The claim must be sent to EMI Health.