PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

THE SCHOOL DISTRICT OF OSCEOLA COUNTY HEALTH SERVICES PLAN

HEALTH CENTER BENEFIT PLAN OPTION

EFFECTIVE DATE: JANUARY 10, 1984

RESTATEMENT DATE: OCTOBER 1, 2024

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INTRODUCTION

This document is a description of **The School District of Osceola County Health Services Plan** (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

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

It would be the responsibility of the Plan to inform the Claims Administrator of any state mandates that would be applicable to the Plan and if there are any benefit changes as a result.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

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

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

A Plan Participant may not assign or transfer any benefits or rights that arise under the Plan or applicable law to any other person, including a healthcare provider, and any purported assignment or transfer is void. This includes (but is not limited to) an attempted assignment or transfer of claims for payment of benefits, breach of fiduciary duty, penalties or any other claim or remedy. For convenience, the Plan may pay any undisputed benefit directly to the healthcare provider, but this is not a waiver of this anti-assignment provision and does not make the healthcare provider an assignee or confer any other rights on the provider. Similarly, the Plan recognizes an authorized representative for purposes of the Plan's claims and appeal procedures, but the authorized representative is not an assignee and has no derivative rights with respect to the claim. However, this anti-assignment provision will not apply (1) to an assignment of a Plan Participant's rights to the Plan or the Plan Administrator, or (2) to the extent required under Medicaid laws.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within *three years* of the date of the Notice of Determination on the final level of review.

The Claims Administrator utilizes *various resources* to determine whether services and procedures are considered Medically Necessary and Experimental and/or Investigational under the Plan. The *information accessed is* based on peer-reviewed, published medical journals, a review of available studies on a particular topic, evidence-based consensus statements, expert opinions of health care professionals and guidelines from nationally recognized health care organizations. These *resources* are reviewed on a regular basis based upon a review of currently available clinical information.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Plan Participants are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Medical Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Covered Charges. Explains when the benefit applies and the types of charges covered.

Claim Review and Audit Program. Program of claim review and auditing to identify charges billed in error, excessive or unreasonable fees, and charges for services which are not Medically Necessary.

Care Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

How to Submit a Claim. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a Plan Participant is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Plan Participant has a claim against another person because of Injuries sustained.

COBRA Continuation Coverage. Explains when a Plan Participant's coverage under the Plan ceases and the continuation options which are available.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Medical Schedule of Benefits are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; charges are reasonable and customary (as defined as an Allowable Charge); and services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all Covered Charges and/or exclusions with specificity. Please contact the Claims Administrator regarding questions about specific supplies, treatments or procedures.

PRE-CERTIFICATION REQUIREMENTS

Pre-certification is required by this Plan.

For medical benefits requiring pre-certification, please contact Pre-certification at the phone number listed on the EBMS/The School District of Osceola County Health Services Plan identification card.

Pre-certification is not a guarantee of benefits, eligibility, payment, nor a medical treatment decision or advice. Please see the Care Management Services section in this booklet for details regarding this pre-certification process.

Penalties for failure to obtain pre-certification will not apply to the maximum out-of-pocket amount.

Pre-certification requirements do not apply to services incurred at The School District of Osceola County Health Center.

For other services that do not require pre-certification, **a pre-notification of services is strongly recommended, but not required by the Plan.** Pre-notification is not a guarantee of benefits, eligibility, payment, nor a medical treatment decision or advice. Please see the Care Management Services section in this booklet for details regarding the pre-notification process.

MEMBER ADVOCACY PROGRAM

For assistance in identifying the right Provider and to ensure Plan Participants receive quality care in a cost-effective manner, this Plan offers a ***Member Advocacy Program***. This Program is available at no cost to the Plan Participant and provides an opportunity to speak to trained medical professionals who will answer questions and provide information to assist the Plan Participant in making the best decisions regarding their health care needs and treatment options.

When a Plan Participant contacts Member Advocacy and abides by the Member Advocacy recommendation, Covered Charges for the specified services will not be subject to deductible; *however, coinsurance and/or copayments will continue to apply.*

This Plan requires referrals to specialty Physicians as stated in the Medical Benefits Schedule.

*Please note that receiving a **Member Advocacy** recommendation does not necessarily mean that all Charges associated with the recommended Facility, Physician, or other healthcare provider are a Covered Charge under the Plan. All claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided.*

***Contact the Member Advocacy Program* toll-free at: (844) 297-0747.**
To access the Member Advocacy Program website, visit:
https://mibenefits.ebms.com/auth/login, and select *Health and Services – Member Advocacy.*

HEALTH CENTER AND OTHER PROVIDER INFORMATION

The primary provider of care (Primary Care Physician, aka "PCP") under this Health Center Benefit Plan Option is **The School District of Osceola County Center for Employee Health, aka *The Health Center*** *(except for Dependent children who choose their Pediatrician as their PCP).* Services that are available through a Primary Care Physician at The Health Center must be incurred through The Health Center to be eligible under the Plan. Services that require the care of a Specialty Physician must have a Health Center referral to a **Tier 1 or Tier 2 Evolutions** Specialty Provider prior to service to be eligible. This referral requirement does not apply to Emergency Services, including ambulance services. Refer to the Medical Schedule of Benefits for additional details.

Reimbursement of services incurred through a Tier 1/Tier 2 Evolutions Provider are reimbursed as shown in the Medical Schedule of Benefits, based on the provider agreement.

Reimbursement of Emergency Services including emergency ambulance services, performed by a Non-Tier 1/Tier 2 Evolutions Provider will be subject to Tier 1/Tier 2 Provider benefits, based on *Allowable Claim Limits* determined under the *Claim Review and Audit Program.* You may contact the Claims Administrator or the Plan Administrator with any questions regarding which providers may be included under the *Claim Review and Audit Program.*

This Plan will allow the following Provider exceptions when Covered Charges are received:

- Services incurred through Florida Lung, Asthma & Sleep Specialists (FLASS):
    - For Plan Participants who have a documented Health Center referral to FLASS, all Covered Charges will be eligible at 100%, no deductible or copayment applies.
    - For Plan Participants who have a documented referral to FLASS from **Pre-certification**, Covered Charges for the specified services will not be subject to deductible.
    - Expenses incurred by FLASS without one of the above referrals are not eligible for reimbursement.
    - Services referred *by FLASS* to another provider are also not eligible for reimbursement.

- If a Plan Participant is traveling outside of The Health Center service area and require urgent or immediate care (and the sole purpose for travel is not for seeking medical treatment), reimbursement for Covered Charges incurred by a **Tier 1/Tier 2 Evolutions Provider** will be based upon the provider agreement. If the urgent or immediate service is not incurred through a Tier 1/Tier 2 Evolutions Provider, reimbursement will be determined based on *Allowable Claim Limit* determined under the *Claim Review and Audit Program.* The Plan Participant may be balance billed by the Provider for any amount over the Allowable Charge.

SPECIALTY PHYSICIAN REFERRAL DENIAL

If the Primary Care Physician (PCP) at the SDOC Center for Employee Health denies a Plan Participant's request for a referral to a Specialty Physician, the Health Center PCP will provide their medical opinion for the denial during either an in-person visit or virtual visit. This denial will be documented in the patient note and a letter memorializing the denial will be produced by the Health Center and sent to the Plan Participant.

If the Plan Participant does not agree with the Health Center PCP's medical reasoning to deny the specialist referral, the Plan Participant may, within 30 days of the decision, request reconsideration of the denial by completing the *reconsideration form* that accompanied the Health Center denial letter. The form must be submitted to the SDOC Administrative Lead of the Health Center's Patient Navigators who will forward it to the appropriate individual (usually the Health Center Medical Director) for review. Within 10 business days of receiving the form, the outcome of the review will be shared with the Administrative Lead of the Health Center's Patient Navigators who in turn will notify the Plan Participant.

If the outcome of the review is adversary to the denial, it will indicate recommendations for the Plan Participant's future care which could include additional medical appointment(s) and/or diagnostic testing. This process will be completed within 45 days of the date the Plan Participant presented their form for reconsideration to the Health Center.

If the denial to refer to a Specialty Physician is upheld, *or the Plan Participant is unwilling to participate in the Medical Director's recommendations,* the Plan Participant may seek a final determination be performed through an Independent Review Organization (IRO). This request must be submitted by the Plan Participant to the SDOC Administrative Lead of the Health Center's Patient Navigators within 30 days of the date of the initial denial, or within 30 days of the subsequent decision to uphold the denial.

The IRO will have 30 days to make a final determination and will provide notice to the SDOC Administrative Lead of the Health Center's Patient Navigators who will subsequently provide the outcome of the review to the Plan Participant. The decision of the IRO is final. Information on this entire procedure is available through The Health Center.

NO SURPRISES ACT (NSA)

For Provider charges subject to the No Surprises Act (NSA) (part of the Consolidated Appropriations Act of 2021), the Plan Participant cost-sharing will be the Tier 1/Tier 2 Evolutions Provider benefit level which will be calculated as if the Allowable Charge was the Recognized Amount. Any such cost-sharing amounts will accrue toward the Tier 1/Tier 2 Evolutions Provider deductible and maximum out-of-pocket amount. The NSA prohibits these non-Tier 1/Tier 2 Providers from pursuing payment from the Plan Participant for the difference between the Allowable Charge and the Provider's billed charge for services, except for any applicable cost-sharing.

Provider charges subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a non-Tier 1/Tier 2 Provider Facility:
    - Provided the Plan Participant has not provided Notice and Consent (as explained below) to waive the applicability of the NSA;
    - Including the furnishing of equipment/devices, labs, imaging, telehealth, pre-operative and post-operative services regardless of being physically located at the Tier 1/Tier 2 Provider Facility; and
- Covered Charges for air ambulance services.

Benefit determinations for Provider claims subject to the NSA will be made within 30 days of the Claims Administrator's receipt of the claim and if applicable, reimbursement will be submitted directly to the Provider.

Notice and Consent. Exceptions to the NSA balance billing protections may apply when the Plan Participant receives non-emergency services (other than ancillary services) from a non-Tier 1/Tier 2 Provider and gives written consent to receive those services *outside the benefits of this Plan.* Ancillary services include anesthesiology, pathology, radiology, neonatology, assistant surgeons, hospitalists, intensivists, and items and services related to emergency medicine.

PROVIDER DIRECTORIES

If a Plan Participant seeks care based on incorrect information indicating that the provider was a Tier 1/Tier 2 Provider at the time the treatment or service was received, the Plan Participant's cost share will be limited to the applicable Tier 1/Tier 2 Provider benefit level if the Plan Participant can provide proof within 30 days that they sought care based on the incorrect information.

CONTINUING CARE PROVISION

In accordance with the Consolidated Appropriations Act of 2021, when a Plan Participant is receiving *authorized* treatment from a Tier 1/Tier 2 Provider, and that provider's relationship with the Plan is terminated, not renewed, or otherwise ends for any reason (other than the Provider's failure to meet applicable quality standards or for fraud), the Plan Participant has rights to elect Continuing Care from the former Tier 1/Tier 2 Provider.

The Plan shall notify the Plan Participant in a timely manner that the Tier 1/Tier 2 Provider's contractual relationship with the Plan has terminated. If the Plan Participant **elects in writing** to receive Continuing Care, benefits will apply under the same terms and conditions as would have applied had the termination not occurred. This Continuing Care Provision becomes available as of the date of the letter received by the Plan Participant that the former Tier 1/Tier 2 Provider is no longer associated with the Plan. The Continuing Care Provision will cease 90 days after that date or when the Plan Participant ceases to receive Continuing Care, whichever occurs first.

Under the Continuing Care Provision, the former Tier 1/Tier 2 Provider must: (a) accept reimbursement from the Plan and any applicable cost sharing from the Plan Participant as payment in full; and (b) continue to adhere to all policies, procedures, and standards of care imposed by the Plan in the same manner as if the Tier 1/Tier 2 Provider termination had not occurred.

For purposes of this provision, a "Continuing Care" Plan Participant is:

(1) undergoing a course of treatment for a serious and complex condition from a specific Tier 1/Tier 2 Provider;
(2) undergoing a course of institutional or inpatient care from a specific Tier 1/Tier 2 Provider;
(3) scheduled to undergo non-elective surgery from a specific Tier 1/Tier 2 Provider, including postoperative care;
(4) pregnant and undergoing a course of treatment for the Pregnancy from a specific Tier 1/Tier 2 Provider; or
(5) terminally ill and receiving treatment for such illness from a specific Tier 1/Tier 2 Provider.

DEDUCTIBLES/COPAYMENTS/COINSURANCE PAYABLE BY PLAN PARTICIPANTS

Deductibles/copayments are dollar amounts that the Plan Participant must pay before the Plan pays.

A **deductible** is an amount of money that is paid once a Plan Year per Plan Participant. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges (except for Covered Charges that are not subject to the deductible). The deductible will apply toward the maximum out-of-pocket amount. *Each **October 1**, a new deductible amount is required.*

Family Unit deductible. When the maximum amount has been incurred by members of a Family Unit toward their Plan Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that Plan Year.

A **copayment** is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments, including Prescription Drug copayments, will not apply toward the deductible. Copayments, including Prescription Drug copayments, will apply to the maximum out-of-pocket amount.

Coinsurance is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Medical Schedule of Benefits and is payable by the Plan Participant until the maximum out-of-pocket amount, as shown in the Medical Schedule of Benefits is reached. Coinsurance *does not* apply to the deductible and *does not* include copayment amounts.

Once the Plan has made the applicable benefit payment as shown in the Medical Schedule of Benefits, the remaining percentage owed is the Plan Participant's "coinsurance" responsibility. For example, if the Plan's reimbursement rate is 80%, the Plan Participant's responsibility (or coinsurance) is 20%.

MAXIMUM OUT-OF-POCKET AMOUNT

Covered Charges are payable by the Plan at the percentages shown each Plan Year until the maximum out-of-pocket amount shown in the Medical Schedule of Benefits is reached. Then, Covered Charges incurred by a Plan Participant will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Plan Year.

When a Family Unit reaches the maximum out-of-pocket amount, Covered Charges for that Family Unit will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Plan Year.

HEALTH CENTER BENEFIT PLAN
MEDICAL SCHEDULE OF BENEFITS

NOTE: ALL DEDUCTIBLES, MAXIMUM OUT-OF-POCKET AMOUNTS, AND BENEFIT MAXIMUMS ACCUMULATE ON A PLAN YEAR BASIS. THE PLAN YEAR IS OCTOBER 1 THROUGH SEPTEMBER 30.

HEALTH CENTER BENEFIT PLAN	SDOC CENTER FOR EMPLOYEE HEALTH	TIER 1 & TIER 2 EVOLUTIONS PROVIDER
ALL SERVICES RENDERED AT A SCHOOL DISTRICT OF OSCEOLA COUNTY CENTER FOR EMPLOYEE HEALTH ARE AVAILABLE AT <u>NO COST</u> TO THE PLAN PARTICIPANT.		
Primary Care Physician (PCP) services are only eligible when incurred through the SDOC Center for Employee Health, except for Dependent children who choose a Tier 1 or Tier 2 Pediatrician as their Primary Care Physician, or Plan Participants age 18 and older who utilize a Tier 1/Tier 2 OB/GYN or GYN. All Plan Participants must obtain a referral either from the SDOC Center for Employee Health or from the Primary Care Pediatrician or Tier 1/Tier 2 OB/GYN or GYN in order to see a Specialty Physician. A Specialist referral is always required, failure to obtain Specialist referral will result in a penalty of non-coverage. Specialist referral: contact SDOC Center for Employee Health at (407) 483-5757. Referral suggested by any other provider than indicated below will not be a Covered Charge. Referred Specialist referring to another Specialist, for referral: contact **Member Advocacy** at (844) 297-0747. Pediatrician, Tier 1/Tier 2 OB/GYN or GYN referring to a Specialist, for referral: contact **Member Advocacy** at (844) 297-0747. **An SDOC Center for Employee Health referral is not required for the following Tier 1 or Tier 2 services:** Primary Care pediatrician; obstetrician or obstetrician/gynecologist; or Mental Health/Substance Abuse provider.		
When a Plan Participant contacts the SDOC Center for Employee Health and follows the SDOC Center for Employee Health referral recommendation, Covered Charges for the specified services will not be subject to deductible. Coinsurance and/or copayments will continue to apply as shown below. Dependent children who select a Tier 1 or Tier 2 Pediatrician as their Primary Care Physician, or Plan Participants age 18 and older who utilize a Tier 1 or Tier 2 OB/GYN or GYN, Plan Participants who contact **Member Advocacy** and abide by the **Member Advocacy** recommendation, will have deductible waived for the specified services. Services that are <u>not available</u> through the SDOC Center for Employee Health, Plan Participants who contact **Member Advocacy** and abide by the **Member Advocacy** recommendation, will have deductible waived for the specified services.		
Claims should be received by the Claims Administrator within *180* days from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be declined. The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.		
DEDUCTIBLE, PER PLAN YEAR		
Per Plan Participant	Not Applicable	$500
Per Family Unit	Not Applicable	$1,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR		
Per Plan Participant	Not Applicable	$4,000
Per Family Unit	Not Applicable	$8,000
The Plan will pay the designated percentage of Covered Charges until maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year, unless stated otherwise.		

HEALTH CENTER BENEFIT PLAN	SDOC CENTER FOR EMPLOYEE HEALTH	TIER 1 & TIER 2 EVOLUTIONS PROVIDER
ALL SERVICES RENDERED AT A SCHOOL DISTRICT OF OSCEOLA COUNTY CENTER FOR EMPLOYEE HEALTH ARE AVAILABLE AT <u>NO COST</u> TO THE PLAN PARTICIPANT.		
The following charges do not apply toward the maximum out-of-pocket amount and are never paid at 100%: • Amounts over the Allowable Charge. • Pre-certification penalties. • Non-covered services. • Prescription Drug Dispense As Written (DAW) penalties, and discounts and coupons provided through Prescription Drug assistance programs, drug manufacturers or Pharmacies.		
Benefits shown below indicate the Plan payment amount, except for copayment amounts (where indicated).		
Hospital Facility Room and Board	Not Available at SDOC Center for Employee Health	80% after deductible
Intensive Care Unit	Not Available at SDOC Center for Employee Health	80% after deductible Hospital's ICU Charge
Note: *Pre-certification is required prior to inpatient admissions to avoid a penalty. See the Care Management Services section for more information.*		
Outpatient Hospital Facility / Outpatient Surgical Center	Not Available at SDOC Center for Employee Health	80% after deductible
Note: *Pre-certification is required prior to outpatient surgery to avoid a penalty. See the Care Management Services section for more information.*		
Emergency Room Services *(includes Facility and Physician charges)*	Not Available at SDOC Center for Employee Health	100% after $400 copayment per visit, deductible does not apply *(copayment waived if admitted)* *Emergency Room Services performed by a non-contracted Provider are eligible subject to the Allowable Claim Limit.*
Note: *Pre-certification subsequent to an inpatient admission from the Emergency Room is required to avoid a penalty. See the Care Management Services section for more information.*		
Skilled Nursing Facility	Not Available at SDOC Center for Employee Health	80% after deductible 60 days Plan Year maximum *(combined with Inpatient Rehabilitation Services)*
Note: *Pre-certification is required prior to inpatient admissions to avoid a penalty. See the Care Management Services section for more information.*		
Rehabilitation Services Inpatient Services	Not Available at SDOC Center for Employee Health	80% after deductible 60 days Plan Year maximum *(combined with Skilled Nursing Facility)*
Outpatient/Office Services	Not Available at SDOC Center for Employee Health	100% after $30 copayment per visit, deductible does not apply ***Therapy visit limits per Plan Year:*** *cardiac rehab – 36 visits; physical, speech, occupational, cognitive, respiratory, and chiropractic care – 60 (combined) visits.* *Visit limits do not apply to treatment related to autism spectrum disorders.*
Note: *Pre-certification is required prior to inpatient admissions to avoid a penalty. See the Care Management Services section for more information.*		
Urgent Care Facility	Not Available at SDOC Center for Employee Health	100% after $45 copayment per visit, deductible does not apply
Note: *The urgent care copayment includes all services incurred during the visit and billed by the same provider. All other services related to the urgent care service will be payable per normal Plan provisions.*		

HEALTH CENTER BENEFIT PLAN	SDOC CENTER FOR EMPLOYEE HEALTH	TIER 1 & TIER 2 EVOLUTIONS PROVIDER
ALL SERVICES RENDERED AT A SCHOOL DISTRICT OF OSCEOLA COUNTY CENTER FOR EMPLOYEE HEALTH ARE AVAILABLE AT NO COST TO THE PLAN PARTICIPANT.		
Retail Health Clinic *(Walk-in Clinic, Convenience Clinic)*	Not Available at SDOC Center for Employee Health	100%, deductible does not apply
Note: *The Retail Health Clinic benefit includes all services incurred during the visit and billed by the same provider. All other services related to the Retail Health Clinic visit will be payable per normal Plan provisions. See Retail Health Clinic in the Covered Charges section for more information.*		
Telehealth Services, TeleVisits	100%, deductible does not apply	Tier 1 & Tier 2 providers: Considered under the applicable plan benefit service, including benefit guidelines. Orlando Health Telehealth/TeleVisits: 100%, deductible does not apply *To schedule an appointment, contact Orlando Health by calling (855) 549-2235, or via email at: RVirtualVisit@orlandohealth.com*
Note: *Refer to the Telehealth benefit in the Covered Charges section for more information.*		
Physician Services Inpatient Services	Not Available at SDOC Center for Employee Health	80% after deductible
Outpatient Services	Not Available at SDOC Center for Employee Health	80% after deductible
Office Visits Primary Care Physician	100%, deductible does not apply	Pediatric Primary Care Physician for Dependent children to age 26 or OB/GYN or GYN for Plan Participants age 18 and older: 100%, deductible does not apply *Other Tier 1/Tier 2 providers are not covered*
Specialty Physician	100%, deductible does not apply *limited to services available at the SDOC Center for Employee Health*	**With an SDOC Center for Employee Health referral:** *If the referring specialist refers to a different Tier 1 or Tier 2 specialist, a referral is required; the referring specialist MUST contact* ***Member Advocacy*** *for the referral.* *Pediatrician, OB/GYN or GYN referring to a Specialist; contact* ***Member Advocacy*** *for the referral.* 100% after $30 copayment per visit; deductible does not apply *Otherwise, not covered*
Note: *The Specialty Physician office visit copayment benefit applies once per visit and applies to the visit charge, lab & x-ray (including ultrasound), injections (including the medication), allergy testing/injections/serum, genetic counseling & testing (not including Genetic Counseling & Testing as payable under ACA as a Preventive Care Service), and office surgery. The copayment benefit also includes services such as lab/pathology/x-ray interpretation and Durable Medical Equipment, related to the visit but billed by a different provider and incurred within five days of the visit. The copayment benefit does not include CPAP devices and CPAP supplies.* *"Specialty Physician" shall NOT INCLUDE a general practitioner, family practitioner, general internist, gynecologist, obstetrician/gynecologist, or pediatrician.* ***Note:*** *Pre-certification is required prior to infusion therapy or specialty pharmaceuticals (J-code) obtained through a Tier 1 or Tier 2 provider, to avoid a penalty. See the Care Management Services section for more information.*		

HEALTH CENTER BENEFIT PLAN	SDOC CENTER FOR EMPLOYEE HEALTH	TIER 1 & TIER 2 EVOLUTIONS PROVIDER
ALL SERVICES RENDERED AT A SCHOOL DISTRICT OF OSCEOLA COUNTY CENTER FOR EMPLOYEE HEALTH ARE AVAILABLE AT <u>NO COST</u> TO THE PLAN PARTICIPANT.		
Surgery (not including surgery in a Physician's office)	Not Available at SDOC Center for Employee Health	80% after deductible
Note: *Pre-certification is required prior to outpatient surgery to avoid a penalty. See the Care Management Services section for more information.*		
Allergy Services – Testing, Injections & Serum Office Visits Primary Care Physician	100%, deductible does not apply	<u>Pediatric Primary Care Physician for Dependent children to age 26 or OB/GYN or GYN for Plan Participants age 18 and older:</u> 100%, deductible does not apply *Other Tier 1/Tier 2 providers are not covered*
Specialty Physician	100%, deductible does not apply; *limited to services available at the SDOC Center for Employee Health*	**With an SDOC Center for Employee Health referral:** *If the referring specialist refers to a different Tier 1 or Tier 2 specialist, a referral is required; the referring specialist MUST contact* ***Member Advocacy*** *for the referral.* *Pediatrician, OB/GYN or GYN referring to a Specialist; contact* ***Member Advocacy*** *for the referral.* 100% after $30 copayment per visit; deductible does not apply *Otherwise, not covered*
Ambulance Service	Not Available at SDOC Center for Employee Health	80% after deductible *Ambulance Services performed by a non-contracted Provider are an eligible expense (subject to the Allowable Claim Limit)*
Chemotherapy and Radiation Treatment	Not Available at SDOC Center for Employee Health	80% after deductible
Wig (or hairpiece due to hair loss resulting from cancer treatment)	Not Available at SDOC Center for Employee Health	80% after deductible
Note: *Pre-certification is required prior to chemotherapy or radiation treatment to avoid a penalty. See the Care Management Services section for more information.*		
Colonoscopy First colonoscopy each Plan Year (including all related services)	Not Available at SDOC Center for Employee Health	100%, deductible does not apply
Any subsequent colonoscopy through the end of the Plan Year	Not Available at SDOC Center for Employee Health	80% after deductible
Note: *Pre-certification is required prior to outpatient surgery (non-routine colonoscopy) to avoid a penalty. See the Care Management Services section for more information.*		

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<tr><td>Quest Diagnostics and LabCorp</td><td colspan="2">100%, deductible does not apply</td></tr>
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<tr><td>Imaging Services/Nuclear Medicine – Outpatient/ Freestanding Imaging Facility (MRI/MRA, CT/PET scans)</td><td>Not Available at SDOC Center for Employee Health</td><td>80% after deductible</td></tr>
<tr><td>Green Imaging, LLC (Plan Participants age 11 and older)</td><td colspan="2">100%, deductible does not apply</td></tr>
<tr><td colspan="3">Note: Refer to the X-rays benefit in the Covered Charges section for more information on Green Imaging, LLC, <u>including transportation assistance</u>. Also, refer to the Preventive Care benefit in this Medical Schedule of Benefits for information on preventive/routine services performed by Green Imaging, LLC.

Note: Pre-certification is required prior to imaging services (MRI/MRA, CT Scan, and PET Scan) <u>obtained through a Tier 1 or Tier 2 provider</u>, to avoid a penalty. Pre-certification is not required if these services are performed through Green Imaging, LLC. See the Care Management Services section for more information.</td></tr>
<tr><td>Durable Medical Equipment, Orthotics and Prosthetics</td><td>100%, deductible does not apply; limited to services available at the SDOC Center for Employee Health</td><td>80% after deductible</td></tr>
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One appliance every
5 Plan Years maximum</td></tr>
<tr><td colspan="3">Note: Pre-certification is required prior to Durable Medical Equipment <u>obtained through a Tier 1 or Tier 2 provider</u>, that exceeds $2,500 (including all Positive Airway Pressure (PAP) machines and humidifiers regardless of cost), to avoid a penalty. See the Care Management Services section for more information.

Note: A pre-authorization of services is required prior to receiving an oral orthotic appliance. Refer to the Orthotic devices and appliances benefit in the Covered Charges section for mre information.</td></tr>
</table>

HEALTH CENTER BENEFIT PLAN	SDOC CENTER FOR EMPLOYEE HEALTH	TIER 1 & TIER 2 EVOLUTIONS PROVIDER
ALL SERVICES RENDERED AT A SCHOOL DISTRICT OF OSCEOLA COUNTY CENTER FOR EMPLOYEE HEALTH ARE AVAILABLE AT NO COST TO THE PLAN PARTICIPANT.		
Genetic Counseling & Testing **Outpatient Services**	Not Available at SDOC Center for Employee Health	80% after deductible
Office Services Primary Care Physician	Not Available at SDOC Center for Employee Health	Pediatric Primary Care Physician for Dependent children to age 26 or OB/GYN or GYN for Plan Participants age 18 and older: 100%, deductible does not apply *Other Tier 1/Tier 2 providers are not covered*
Specialty Physician	Not Available at SDOC Center for Employee Health	**With an SDOC Center for Employee Health referral:** *If the referring specialist refers to a different Tier 1 or Tier 2 specialist, a referral is required; the referring specialist MUST contact **Member Advocacy** for the referral.* *Pediatrician, OB/GYN or GYN referring to a Specialist; contact **Member Advocacy** for the referral.* 100% after $30 copayment per visit; deductible does not apply *Otherwise, not covered*
***Note:** Genetic Counseling is limited to 3 visits Plan Year maximum for outpatient and office combined.* ***Note:** The above Genetic Services do not include Genetic Counseling & Testing as payable under ACA as a Preventive Care Service.*		
Home Health Care	Not Available at SDOC Center for Employee Health	80% after deductible 16 hours daily maximum
***Note:** Pre-certification is required prior to Home Health Care Services to avoid a penalty. See the Care Management Services section for more information.*		
Home Infusion Therapy	Not Available at SDOC Center for Employee Health	80% after deductible
***Note:** Pre-certification is required prior to Home Infusion Therapy or specialty pharmaceuticals (J-code), to avoid a penalty. See the Care Management Services section for more information.*		
Hospice Care	Not Available at SDOC Center for Employee Health	80% after deductible
***Note:** Pre-certification is required prior to Hospice Care to avoid a penalty. See the Care Management Services section for more information.*		
Infusion Therapy	Not Available at SDOC Center for Employee Health	80% after deductible
***Note:** Pre-certification is required prior to Infusion Therapy or specialty pharmaceuticals (J-code), to avoid a penalty. See the Care Management Services section for more information.*		
Mammogram First mammogram each Plan Year	Not Available at SDOC Center for Employee Health	100%, deductible does not apply
Any subsequent mammogram through the end of the Plan Year	Not Available at SDOC Center for Employee Health	80% after deductible

HEALTH CENTER BENEFIT PLAN	SDOC CENTER FOR EMPLOYEE HEALTH	TIER 1 & TIER 2 EVOLUTIONS PROVIDER
ALL SERVICES RENDERED AT A SCHOOL DISTRICT OF OSCEOLA COUNTY CENTER FOR EMPLOYEE HEALTH ARE AVAILABLE AT <u>NO COST</u> TO THE PLAN PARTICIPANT.		
Mental Disorders and Substance Abuse Treatment Inpatient Facility	Not Available at SDOC Center for Employee Health	80% after deductible
Inpatient Physician	Not Available at SDOC Center for Employee Health	80% after deductible
Outpatient Facility	Not Available at SDOC Center for Employee Health	80% after deductible
Outpatient Physician	Not Available at SDOC Center for Employee Health	80% after deductible
Office Visits Primary Care Physician	100%, deductible does not apply	<u>Pediatric Primary Care Physician for Dependent children to age 26 or OB/GYN or GYN for Plan Participants age 18 and older:</u> 100%, deductible does not apply *Other Tier 1/Tier 2 providers are not covered*
Specialty Physician	100%, deductible does not apply	100% after $30 copayment per visit; deductible does not apply
Note: *The Specialty Physician office visit copayment benefit applies once per visit and applies to the visit charge, lab & x-ray (including ultrasound), injections (including the medication), allergy testing/injections/serum, genetic counseling & testing (not including Genetic Counseling & Testing as payable under ACA as a Preventive Care Service), and office surgery. The copayment benefit also includes services such as lab/pathology/x-ray interpretation and Durable Medical Equipment, related to the visit but billed by a different provider and incurred within five days of the visit. The copayment benefit does <u>not</u> include CPAP devices and CPAP supplies.* *"Specialty Physician" shall NOT INCLUDE a general practitioner, family practitioner, general internist, gynecologist, obstetrician/gynecologist, or pediatrician.* ***Note:*** *Pre-certification is required prior to inpatient admissions, infusion therapy, and specialty pharmaceuticals (J-code) to avoid a penalty. See the Care Management Services section for more information.*		
Organ Transplants	Not Available at SDOC Center for Employee Health	Payable per normal Plan provisions
Transportation and Lodging	Not Available at SDOC Center for Employee Health	80% after deductible $10,000 per transplant procedure maximum
Note: *Refer to Organ Transplants in the Covered Charges section for more information.* ***Note:*** *Pre-certification is required prior to inpatient admissions to avoid a penalty. See the Care Management Services section for more information.*		

HEALTH CENTER BENEFIT PLAN	SDOC CENTER FOR EMPLOYEE HEALTH	TIER 1 & TIER 2 EVOLUTIONS PROVIDER
ALL SERVICES RENDERED AT A SCHOOL DISTRICT OF OSCEOLA COUNTY CENTER FOR EMPLOYEE HEALTH ARE AVAILABLE AT <u>NO COST</u> TO THE PLAN PARTICIPANT.		
Pregnancy Initial Office visit Primary Care Physician	100%, deductible does not apply	<u>Pediatric Primary Care Physician for Dependent children to age 26:</u> 100%, deductible does not apply Services performed by an OB/GYN or GYN *(no referral is required)* 100% after $30 copayment per visit; deductible does not apply *Other Tier 1/Tier 2 providers: Not Covered*
Initial Office visit Specialty Physician	100%, deductible does not apply	**With an SDOC Center for Employee Health referral:** *If the referring specialist refers to a different Tier 1 or Tier 2 specialist, a referral is required; the referring specialist MUST contact **Member Advocacy** for the referral.* *OB/GYN or GYN referring to a Specialist; contact **Member Advocacy** for the referral.* 100% after $30 copayment per visit; deductible does not apply; *Otherwise, not covered*
Routine prenatal office visits	Not Available at SDOC Center for Employee Health	100%, deductible does not apply *If global maternity fee:* 40% of Covered Charges will be payable at 100%, deductible does not apply; thereafter, 80% after deductible
All other Pregnancy Services	Not Available at SDOC Center for Employee Health	80% after deductible
Note: *Refer to the Coverage of Pregnancy benefit listed in the Covered Charges section for more information regarding routine prenatal office visits.* ***Note:*** *Pre-certification of maternity admissions that exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery is required to avoid a penalty. See the Care Management Services section for more information.*		
Routine Well Newborn Nursery Care (while Hospital confined at birth)	Not Available at SDOC Center for Employee Health	80% after deductible
Note: *Pre-certification of maternity admissions that exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery is required to avoid a penalty. See the Care Management Services section for more information.*		
Newborn & Infant Hearing Screening, including follow-up *(not including newborn hearing screenings, payable under ACA as a Preventive Care service)*	Not Available at SDOC Center for Employee Health	Payable per normal Plan provisions
Note: *Refer to the Newborn & Infant Hearing Screening benefit in the Covered Charges section for more information.*		

HEALTH CENTER BENEFIT PLAN	SDOC CENTER FOR EMPLOYEE HEALTH	TIER 1 & TIER 2 EVOLUTIONS PROVIDER
ALL SERVICES RENDERED AT A SCHOOL DISTRICT OF OSCEOLA COUNTY CENTER FOR EMPLOYEE HEALTH ARE AVAILABLE AT NO COST TO THE PLAN PARTICIPANT.		
Preventive Care		
Routine Well Care **Refer to the separate colonoscopy and mammogram benefits in the Schedule.**	100%, deductible does not apply	Pediatric Primary Care Physician for Dependent children to age 26 or OB/GYN or GYN for Plan Participants age 18 and older: 100%, deductible does not apply When the Pediatric Primary Care Physician or OB/GYN or GYN is unable to perform the service, a referral is required from ***Member Advocacy***: 100%, deductible does not apply *Otherwise, not covered* When the SDOC Center for Employee Health Primary Care Physician is unable to perform the service, a referral is required from the ***SDOC Center for Employee Health***: 100%, deductible does not apply *Otherwise, not covered*

Routine Well Care Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF), *unless otherwise specifically stated in this Medical Schedule of Benefits*, and which can be located using the following website:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results

Routine Well Care Services will include, but will not be limited to, the following routine services:
Office visits, routine physical exams, prostate screening*, routine lab and x-ray** services, immunizations, routine colonoscopy***/flexible sigmoidoscopy, and routine well childcare examinations.

Note: If applicable, this Plan may comply with a state vaccine assessment program.

Women's Preventive Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), unless otherwise specifically stated in this Medical Schedule of Benefits, and which can be located using the following websites:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results; and
https://www.hrsa.gov/womens-guidelines

Women's Preventive Services, will include, but will not be limited to, the following routine services:
Office visits, well-women visits, mammogram****, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), counseling and screening for interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity (this does not include birthing classes), preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.

Note: *Cologuard® or an equivalent is allowed under Preventive Care.*

Note: *The Plan will allow for routine prostate screenings under this benefit in addition to those outlined under the USPSTF (Grade C & D recommendations), when recommended by a Physician.*

****Note:*** *In addition to the ACA required coverage of preventive/routine x-ray and imaging services (as determined by the USPSTF), the Plan will allow preventive/routine services outside the ACA guidelines under this Preventive Care benefit, when performed by Green Imaging, LLC.*

****Note**: Refer to the separate colonoscopy benefit in the Schedule.*

*****Note**: Refer to the separate mammogram benefit in the Schedule.*

HEALTH CENTER BENEFIT PLAN	SDOC CENTER FOR EMPLOYEE HEALTH	TIER 1 & TIER 2 EVOLUTIONS PROVIDER
ALL SERVICES RENDERED AT A SCHOOL DISTRICT OF OSCEOLA COUNTY CENTER FOR EMPLOYEE HEALTH ARE AVAILABLE AT <u>NO COST</u> TO THE PLAN PARTICIPANT.		
Diabetic Education	100%, deductible does not apply	100%, deductible does not apply
Nutritional Education Counseling	100%, deductible does not apply	100%, deductible does not apply 3 visits Plan Year maximum
Obesity Interventions for Plan Participants age 18 and older with a body mass index (BMI) of 30 kg/m^2 or higher	100%, deductible does not apply	100%, deductible does not apply
Tobacco/Nicotine Cessation Counseling	100%, deductible does not apply	100%, deductible does not apply
Renal Dialysis Inpatient – Facility/Physician	Not Available at SDOC Center for Employee Health	80% after deductible
Outpatient – Facility/Physician	Not Available at SDOC Center for Employee Health	80% after deductible
Outpatient Facility Renal Dialysis *(not available at SDOC Center for Employee Health, and not performed by a Tier 1 or Tier 2 provider)*	80% after deductible *(subject to the Tier 1/Tier 2 deductible and maximum out-of-pocket)*	
Note: *Pre-certification is required prior to renal dialysis to avoid a penalty. See the Care Management Services section for more information.* ***Note:*** *Covered Charges for Outpatient Facility renal dialysis services performed by a non-Tier 1/non-Tier 2 Provider will be considered at the Usual and Customary amount which, at the Plan Administrator's sole discretion, will not exceed 125% of the current Medicare allowable fee for the treatment, supplies, and/or services for the appropriate area as such information is made publicly available.*		
Sleep Study *(Freestanding Facility, Outpatient Hospital, or in the Home)*	Not Available at SDOC Center for Employee Health	80% after deductible
Note: *Pre-certification is required prior to sleep studies (overnight sleep studies performed at a Facility/sleep Facility), to avoid a penalty. See the Care Management Services section for more information.*		
Specialty Pharmaceuticals (J-code)	Not Available at SDOC Center for Employee Health	Payable per normal Plan provisions
Note: *Pre-certification is required prior to receiving a specialty pharmaceutical (J-code) administered under the medical benefits of this Plan (not those received through the Prescription Drug Benefits of this Plan), to avoid a penalty. See the Care Management Services section for more information.*		
Spinal Manipulation / Chiropractic Care	100%, deductible does not apply	**If referred by the SDOC Center for Employee Health:** 100% after $30 copayment per visit, deductible does not apply; Otherwise, Not Covered *60 visits (combined) Plan Year maximum* *Visit limit includes chiropractic care, physical, speech, occupational, cognitive, & respiratory therapies*
Note: *Diagnostic labs and x-rays related to Spinal Manipulation/Chiropractic Care are payable under the separate Diagnostic Testing benefit.*		

HEALTH CENTER BENEFIT PLAN	SDOC CENTER FOR EMPLOYEE HEALTH	TIER 1 & TIER 2 EVOLUTIONS PROVIDER
ALL SERVICES RENDERED AT A SCHOOL DISTRICT OF OSCEOLA COUNTY CENTER FOR EMPLOYEE HEALTH ARE AVAILABLE AT <u>NO COST</u> TO THE PLAN PARTICIPANT.		
Temporomandibular Joint Disorder (TMJ)	Not Available at SDOC Center for Employee Health	80% after deductible
Note: *A pre-authorization of services is required prior to beginning of any course of treatment for or related to TMJ. Refer to the Temporomandibular Joint Disorder benefit in the Covered Charges section for more information.* ***Note:*** *TMJ benefits include coverage of mouth guards, splints, or occlusal appliances; limited to one item every three Plan years.* ***Note:*** *Pre-certification is required prior to inpatient admissions or outpatient surgery to avoid a penalty. See the Care Management Services section for more information.*		
All Other Covered Charges	100%, deductible does not apply; *if available at SDOC Center for Employee Health*	80% after deductible

HEALTH CENTER BENEFIT PLAN
PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Deductible does not apply to Prescription Drug benefits under the Health Center Benefit Plan option.
Benefit amounts shown below represent the Plan Participant's responsibility.

Covered Charges for Prescription Drugs obtained at the following pharmacies accrue toward the Tier 1/Tier 2 Providers maximum out-of-pocket amount as shown in the Medical Schedule of Benefits:
Prescriptions Unlimited Pharmacy
Publix Pharmacy
Walmart Pharmacy

Prescription Drugs obtained through a retail Pharmacy other than a *Prescriptions Unlimited Pharmacy, Publix, or Walmart* are not eligible for reimbursement.

Designated Retail Pharmacy – *up to a 90-day supply per prescription.*

Generic drugs	$0 copayment per prescription
Generic Prescription Drugs obtained through the School District of Osceola County Center for Employee Health are also available at no cost to the Plan Participant.	
Preferred Brand Name drugs	$45 copayment per prescription
Non-Preferred Brand Name drugs.....	50% copayment up to $150 maximum per prescription

Specialty Drugs – *limited to a 30-day supply per prescription and must be obtained through the Specialty Pharmacy Program.*

Specialty drugs	$75 copayment per prescription

Prescription Drugs purchased through a Pharmacy *other than* a Prescriptions Unlimited Pharmacy, Publix Pharmacy, Walmart Pharmacy, or through the School District of Osceola County Center for Employee Health, **will not be covered** unless specifically provided in the case of an emergency and the Plan Participant is unable to obtain them from one of the designated Pharmacies or through the School District of Osceola County Center for Employee Health. The Plan Participant will be required to pay 100% of the total cost at the point of sale for the emergency Prescription Drug, no discount will be given, and the Plan Participant will be required to submit the prescription receipt to **Ventegra** for reimbursement up to the amount paid, less any applicable copayment as shown in the Prescription Drug Schedule of Benefits.

Note: If a Plan Participant requests a Brand name drug when a Generic equivalent is available, then the Plan Participant must pay the difference in cost between the Generic drug and the Brand name drug in addition to the applicable Brand name drug copayment amount (if any). This difference in payment ***will not apply*** *to the Tier 1/Tier 2 maximum out-of-pocket amount as stated in the Medical Schedule of Benefits.*

Prescription Drug Dispense As Written (DAW) penalties, and discounts and coupons provided through Prescription Drug assistance programs, drug manufacturers or Pharmacies will not apply toward the maximum out-of-pocket amount.

ElectRx International Mail Order Program
A voluntary option to save money on certain high cost Brand Name Prescription Drugs through the ElectRx International Mail Order Program. This program is known as Personal Importation or PI. Certain Brand Name drugs can be ordered from preferred pharmaceutical countries such as Canada, England, and New Zealand, using the same "brick and mortar" pharmacies that people in Canada use for their medications. Refer to ElectRx for the list of Brand Name Prescription Drugs that is eligible for dispensing through this program.

Plan Participants will have **$0 copayment** on each 30 or 90-day fill including subsequent refills on these medications.

Physicians may prepare a prescription for a 30 or 90-day supply with 3 refills and FAX it to ElectRx toll free: (833) 353-2879.

For questions, assistance or information regarding the enrollment process, please contact *ElectRx:*

Toll free at: (855) 353-2879
Website: https://www.electrx.com/

EBMS does not administer any benefits or payments for clients utilizing ElectRx. ElectRx is a different entity in whole and shall be considered such under this health plan document.

Additional information regarding the Prescription Drug Benefit may be found in the separate Prescription Drug Benefits section of this document.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligibility for participation under this Plan is determined by the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

- Is in a class of eligible Employees based on job classification as determined by the Employer.

Eligible Classes of Dependents. A "**Dependent**" is any one of the following persons:

(1) A covered **Employee's Spouse,** *who is a resident of the United States***.**

The term "**Spouse**" shall mean the person to whom the covered Employee is legally married. This Plan also allows coverage for same sex and opposite sex Domestic Partners and civil unions. This Plan does not allow coverage for common-law marriage.

The term "**Domestic Partner**" shall mean the person of the opposite sex or same sex who is currently registered with the Employer as the Domestic Partner of the Employee.

An individual is a Domestic Partner of a covered Employee if that individual and the covered Employee meet each of the following requirements:

(a) The covered Employee and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract;

(b) The covered Employee and the individual are not married or in a domestic partnership to anyone else;

(c) The covered Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside;

(d) The covered Employee and the individual share the same principal residence(s); and

(e) The domestic partnership must have been in existence for a period of at least 12 consecutive months.

To obtain more detailed information or to apply for this benefit, the covered Employee must contact the Plan Administrator. In the event the domestic partnership is terminated, either partner is required to inform the Plan Administrator of the termination of the domestic partnership.

For the purposes of this Plan, all references to Spouse will also be applicable to a Domestic Partner or civil union unless otherwise indicated.

The Plan Administrator may require documentation proving a legal marriage and/or domestic partnership/civil union.

(2) A covered **Employee's Dependent child(ren),** *who is a resident of the United States***.**

A covered Employee's "**Dependent child**" includes natural child, stepchild, Foster Child, adopted child, or a child placed with the covered Employee in anticipation of adoption. Coverage is available to the Dependent children of the Domestic Partner/civil union provided that the children otherwise meet the Dependent child eligibility requirements of the Plan.

"**Foster Child**" means a child who meets the eligibility requirements for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county or private foster care agency.

A covered Foster Child is <u>not</u> a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

A "**stepchild**" means a child who meets the eligibility requirements of this Plan for whom a covered Employee is the step-parent of the child(ren).

If a covered Employee is the **Legal Guardian** of a child or children, these children may be enrolled in this Plan as covered Dependents.

"**Legal Guardian**" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

The phrase "**child placed with a covered Employee in anticipation of adoption**" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Please be advised, the definition of "Dependent" may not be the same definition as established by the Internal Revenue Code (IRC) for individuals that the covered Employee is permitted to pay qualified medical expenses from a Health Savings Account (HSA), or individuals that can be enrolled as an eligible Dependent for tax-free benefits (i.e., Domestic Partner or non-IRC Section 152 dependent). There may be tax implications for the Employee if he or she enrolls certain eligible Dependent(s). The Employee should consult his or her tax advisor with any questions on the tax consequences of benefits for his or her eligible Dependent(s).

The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

(3) A **child** of a covered **Employee's** covered **Dependent child,** from birth to age 18 months, as long as the Dependent child was enrolled under this Plan at the time of birth of the grandchild.

(4) A covered **Employee's Dependent child,** *who is a resident of the United States,* **from the age of 26 to the limiting age of 30**, *in accordance with Florida Statute §627.6562, Dependent coverage,* provided the Dependent child meets ALL of the following requirements:

- Is unmarried; and
- Does not have a dependent of their own; and
- Is a Florida state resident, OR a full-time or part-time student; and
- Is not covered under health plan coverage of their own; and
- Is not entitled to benefits under Title XVIII of the Social Security Act.

The Plan Administrator may require documentation proving the above eligibility requirements once per year until the Dependent child reaches age 30.

As related to maintaining full-time (or part-time) student status, ***"Michelle's Law"*** *prohibits a group health plan or health plan issuer from terminating coverage of a Dependent child due to a qualifying "Medically Necessary Leave of Absence" from a postsecondary educational institution prior to certain criteria being satisfied. Coverage of a Dependent child enrolled under this overage provision will not cease if the Dependent child's failure to maintain full-time (or part-time) student status (or other change in school enrollment such as a reduction of credit hours), is due to a* ***Medically Necessary leave of absence.***

If the Dependent child's treating Physician certifies in writing that the Dependent child is suffering from a serious Illness or Injury, and that the leave of absence or other change in enrollment is Medically Necessary, coverage may continue for up to one year after the date the Medically Necessary leave of absence or other change in enrollment begins.

To be eligible for the extension, the Dependent child must be enrolled in the Plan as a full-time (or part-time) student immediately before the first day of the Medically Necessary leave of absence. This extension of coverage continues to apply if the manner of providing coverage under the Plan changes (such as from self-funded to fully insured), if the changed coverage continues to provide coverage for Dependent children.

However, this extension does not extend coverage beyond the date that a Dependent child fails to meet the Dependent eligibility requirements other than the requirement to be a full-time (or part-time) student.

(5) A **covered Dependent child who reaches the limiting age** and is **Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee, for support and maintenance. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

"**Total Disability (Totally Disabled)**" means the complete inability as a result of Injury or Illness to perform the normal activities of a person of like age and sex in good health.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: Other individuals living in the covered Employee's home, but who are not eligible as defined; the divorced former Spouse of the Employee; the former Domestic Partner/civil union Spouse of the Employee; or any person who is covered under the Plan as an Employee.

If a Plan Participant changes status from Employee to Dependent or Dependent to Employee, and the Plan Participant is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both parents are Employees, their children may be covered as Dependent children of one of the parents, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan.

For Employee Coverage: The Employer shares the cost of Employee coverage under this Plan with the covered Employee.

For Dependent Coverage: The Employee pays the cost of Dependent coverage under this Plan.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by completing an enrollment application along with the appropriate payroll deduction authorization, if applicable. If Dependent coverage is desired, the covered Employee will be required to enroll the Dependent(s).

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee *or a covered Dependent child* is automatically enrolled in this Plan for the first 31 days from the date of birth. In order to continue coverage beyond the 31st day, the covered Employee must enroll the newborn child on a timely basis, as defined in the section "Timely Enrollment" following this section. If the covered Employee fails to enroll the newborn child on a timely basis, there will be no further payment from the Plan following the first 31 days from the date of birth.

A newborn child of a Dependent child is not eligible to enroll as a Late Enrollee.

A newborn child of a Dependent child is not eligible under this Plan unless the newborn child meets definition of an eligible Dependent.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** – The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

(2) **Late Enrollment** – An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their eligible Dependents who were not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment. *A newborn child of a Dependent child is not eligible to enroll during open enrollment.*

Unless otherwise required by law, if an individual loses eligibility for coverage as a result of terminating employment, reduction of hours of employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period. Coverage begins as stated in the Open Enrollment section below.

Open Enrollment – Each year there is an annual open enrollment period designated by the Employer during which eligible Employees may enroll themselves and any eligible Dependents under the Plan or covered Employees may change their and their covered Dependents' benefit elections under the Plan.

Benefit choices made during the open enrollment period will become effective **October 1.**

Plan Participants will receive detailed information regarding open enrollment from their Employer.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for themselves or their Dependents because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, domestic partnership/civil union, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days of the birth, marriage, registration of domestic partnership/civil union, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. **To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.**

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

(1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and the loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual; and

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment; and

(c) Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated; and

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. *If the required enrollment paperwork is received by Risk and Benefits Management no later than 31 days after the date of the event,* coverage will begin the first day of the first month following the date of loss.

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

(i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).

(ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, *termination of domestic partnership/civil union*, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Acquiring a newly eligible Dependent may create a Special Enrollment right. If:

(a) The Employee is a participant under this Plan (or the Employee is eligible, but not enrolled in this Plan), and

(b) A person becomes a Dependent of the Employee through marriage, domestic partnership/civil union, birth, adoption, or placement for adoption,

then the Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for their eligible Dependents to enroll.

The Special Enrollment Period for newly eligible Dependents is a period of 31 days that begins after the date of the marriage, registration of domestic partnership/civil union, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period. In the case of birth, adoption, or placement for adoption, the Spouse of the covered Employee may also be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage or domestic partnership, as of the first day of the first month following the timely receipt of the request for enrollment;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, appointment of Legal Guardianship, or Foster Child placement, as of the date of the adoption or placement for adoption, appointment of Legal Guardianship, or Foster Child placement.

(3) Medicaid or Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Employees and their Dependents who are otherwise eligible for coverage under the Plan, but who are not enrolled, can enroll in the Plan provided they request enrollment within 60 days from the date of the following loss of coverage or gain in eligibility if:

(a) The Employee or Dependent cease to be eligible for Medicaid or a state Children's Health Insurance Program (CHIP) coverage; or

(b) The Employee or Dependent become newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Employee and/or Dependent may enroll under this Plan. If the Employee is not enrolled at the time of the event, he or she must enroll under this Special Enrollment Period in order for their eligible Dependent to enroll.

This Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment during this 60-day period. The effective date of coverage will be the first day of the first month following the date of loss of coverage or gain in eligibility.

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the Employer, and its Employees.

For more information regarding special enrollment rights, contact the Plan Administrator.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the first month following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. **If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.** The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated;

(2) The day termination of Employment occurs;

(3) August 1st at 11:59 p.m. of the current contract year when an Active Employee retires or resigns. (*See below for scenarios explaining End of School Year Benefit End Dates.);

(4) The date in which the covered Employee ceases to be in a class of eligible Employees as determined by the Employer. This includes death or termination of active employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) This also includes an Employee on disability leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods;

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or

(6) As otherwise specified in the Eligibility section.

Note: Except in certain circumstances, a covered Employee may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

***End of School Year Benefit End Dates -** The following scenarios explain how benefits are affected when an Employee terminates employment at the end of their current contract.

An Employee won't lose their benefits at the end of the current contract if he or she:

- *Resigns at the end of the current contract.* If he or she would have been reappointed for the coming year but know they will not be returning for the new contract year, he or she can resign their position immediately and have insurance benefits available to them until the day before they are due to return to work for the following school year.

- *Would have been reappointed however a position is not available due to a reduction in force (RIF).* Benefits will terminate the day before he or she is due to return to work for the following school year.

- *Is granted a Leave of Absence (LOA) for the coming year and works until the end of the current contract.* Benefits will continue until 11:59 p.m., August 1st. Employees on an LOA will have the option of keeping their benefits during the leave. A letter detailing insurance options will be sent to the LOA Employee automatically.

- *Retires at the end of their current contract.* Benefits will remain in effect until 11:59 p.m., August 1st. Retirees will have the option of keeping their benefits. A letter detailing insurance options will be sent to the retiree automatically.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. Coverage for an Employee and enrolled Dependents may be continued for a limited period of time if the Employee's active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as determined by the Employer.

If Employee's leave qualifies under the Family and Medical Leave Act (FMLA), any continuation of coverage provided under this provision will *run concurrent with FMLA.*

Coverage under this provision will continue in accordance with the same terms and conditions of an Active Employee. If a COBRA qualifying event occurs, any period of continued coverage under this section will not reduce the maximum time for which the Employee may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

Continuation During Family and Medical Leave. When applicable, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor and amended from time to time, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations.

This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees.

Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other State leave law, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and their covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A covered Employee who is terminated and rehired prior to the end of a *26-consecutive week period* after the date of termination will be eligible to re-enroll the first day of the first calendar month following the date of rehire. Employees rehired after a break in service of 26-consecutive weeks or more will be treated as a new hire.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 24-month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA Continuation Coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

The Civilian Reservist Emergency Workforce Act of 2021 ("The CREW Act"). The CREW Act provides eligible Employees who are called to service by the Federal Emergency Management Agency (FEMA), continuation of coverage rights under USERRA.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

(1) The date the Plan or Dependent coverage under the Plan is terminated;

(2) The date that the Employee's coverage under the Plan terminates. (See the section entitled COBRA Continuation Coverage.);

(3) The date a covered Spouse (including Domestic Partnership/civil union Spouse) ceases to meet the eligibility requirements. (See the section entitled COBRA Continuation Coverage.);

(4) The date a Dependent child ceases to meet the applicable eligibility requirements except when the Dependent child has reached the limiting age of 26 *or when coverage due to a QMCSO is no longer required*, at which time coverage will end the last day of the month in which the event occurred. (See the section entitled COBRA Continuation Coverage.);

(5) The date a Dependent child's coverage terminates will also apply to the termination of coverage of a child of a Dependent child. (See the section entitled COBRA Continuation Coverage.);

(6) The day the child of a Dependent child reaches age 18 months. (See the section entitled COBRA Continuation Coverage.);

(7) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or

(8) As otherwise specified in the Eligibility section.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Plan Participant for care of an Injury or Illness and while the Plan Participant is covered for these benefits under the Plan.

Claims should be received by the Claims Administrator within *180 days* from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within *three years* of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

COVERED CHARGES

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

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Medical Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Charges for an Intensive Care Unit stay are payable as described in the Medical Schedule of Benefits.

Note: *Pre-certification is required prior to inpatient admissions or outpatient surgery to avoid a penalty. See the Care Management Services section for more information.*

(2) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Illness and will be payable as shown in the Medical Schedule of Benefits.

Note: Routine prenatal office visits will be payable as shown under the Pregnancy benefit in the Medical Schedule of Benefits. The following services will continue to be payable per normal Plan provisions:

> Pregnancy-related ultrasounds, lab screenings (not otherwise specified), Complications of Pregnancy (as defined under this Plan), delivery, and post-partum care.

Covered Charges include expenses related to termination of pregnancy (both elective and non-elective).

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Note: *Pre-certification of maternity admissions that exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery is required to avoid a penalty. See the Care Management Services section for more information.*

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the Plan Participant is confined as a bed patient in the Facility; and

(b) the attending Physician certifies that the confinement is deemed Medically Necessary; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Plan Participant's care in these Facilities are payable as shown in the Medical Schedule of Benefits.

Note: *Pre-certification is required prior to inpatient admissions to avoid a penalty. See the Care Management Services section for more information.*

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for multiple surgical procedures are subject to the following provisions in the absence of a negotiated amount established by a provider agreement, arrangement, or other discounting or negotiated arrangement:

(a) If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Allowable Charge for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision or during the same operative session. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Allowable Charge percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Allowable Charge.

Note: *Pre-certification is required prior to inpatient admissions or outpatient surgery to avoid a penalty. See the Care Management Services section for more information.*

(5) **Home Health Care Services and Supplies.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Illness. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services are subject to the Home Health Care limit shown in the Medical Schedule of Benefits. A home health care visit will be considered a periodic visit *of two hours or less*, by either a nurse or therapist, as the case may be.

Note: *Pre-certification is required prior to Home Health Care Services to avoid a penalty. See the Care Management Services section for more information.*

(6) **Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Plan Participant'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.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Medical Schedule of Benefits *and includes respite care.*

Bereavement counseling services by a health care provider acting within the scope of his or her license for the Plan Participant's immediate family (covered Employee, covered Spouse and/or other covered Dependent children). Bereavement services must be furnished within six months after the Plan Participant's death.

Note: *Pre-certification is required prior to Hospice Care to avoid a penalty. See the Care Management Services section for more information.*

(7) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) **Allergy.** Care, supplies, services and treatment in connection with allergy testing, serum and injections.

(b) **Ambulance.** Local Medically Necessary professional land, *water, rail,* or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(c) **Anesthetic**; oxygen; intravenous injections and solutions. Administration of these items is included.

(d) **Blood and blood derivatives**; that are not donated or replaced. *Processing, storage, and administrative services for autologous blood (a Plan Participant's own blood) when a Plan Participant is scheduled for surgery that can be reasonably expected to require blood.*

(e) **Breast pump, breast pump supplies, lactation support and counseling.**

Breast pump, breast pump supplies

A standard electric breast pump or a manual breast pump for initiation or continuation of breastfeeding may be bought rather than rented, with the cost to rent not to exceed the actual purchase price.

- *Rental of a heavy duty/Hospital grade breast pump per birth.* Purchase of a heavy duty/Hospital grade breast pump is not considered Medically Necessary or a Covered Charge under this Plan.
- For female Plan Participants using a breast pump from a prior Pregnancy, a new set of breast pump supplies will be covered with each subsequent Pregnancy.
- A standard electric breast pump or a manual breast pump, but not both, will be *eligible for purchase once per* Pregnancy.

Covered Charges for the purchase or rental of a breast pump and supplies will be payable subject to the Preventive Care benefits as shown in the Medical Schedule of Benefits.

Note: *Breast pumps and breast pump supplies when purchased through a retail store (for example, through Target, Wal-Mart, Walgreens) will be considered payable at the* ***Tier 1 Provider*** *benefit level only for the purposes of this benefit. The Claims Administrator will require the following documentation: claim form with proof of purchase to include purchase price and item description.*

Lactation support and counseling

Covered Charges include inpatient and outpatient comprehensive prenatal and postnatal lactation support and counseling for female Plan Participants for the duration of the breastfeeding. Services must be rendered by a Physician acting within the scope of their license or certification under applicable State law.

Note: *Payment will be made under the* ***Tier 1 Provider*** *Preventive Care benefit level as shown in the Medical Schedule of Benefits, for Covered Charges for lactation support and counseling*.

(f) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion, coronary bypass surgery, or other cardiac condition; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(g) **Chemotherapy or radiation treatment** with radioactive substances. The materials and services of technicians are included.

Note: *Pre-certification is required prior to chemotherapy or radiation treatment to avoid a penalty. See the Care Management Services section for more information.*

(h) ***Cleft Lip and Cleft Palate.*** Medically Necessary care prescribed by a Physician for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology, and nutrition services. Covered Charges are subject to specific benefits and/or limitations as applicable to the type of treatment incurred.

Note: *Pre-certification is required prior to inpatient admissions or outpatient surgery to avoid a penalty. See the Care Management Services section for more information.*

(i) **Clinical Trials.** Covered Charges will include charges made for routine patient services associated with clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:

- The clinical trial is registered on the National Institute of Health (NIH) maintained web site www.clinicaltrials.gov as a Phase I, II, III, or IV clinical trial;
- The Plan Participant meets all inclusion criteria for the clinical trial and is not treated "off-protocol";
- The Plan Participant has signed an Informed Consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed Informed Consent;
- The trial is approved by the Institutional Review Board of the institution administering the treatment; and
- Routine patient services will not be considered Experimental or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Plan Participant would receive whether or not he or she were participating in a clinical trial.

Routine patient services do not include, and reimbursement will not be provided for:

- The Investigational service, supply, or drug itself;
- Services or supplies listed herein as Plan Exclusions;
- Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs). This includes items and services provided solely to satisfy data collection and analysis and that are not used in direct clinical management of the Plan Participant (e.g., monthly CT scans for a condition usually requiring only a single scan); and
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

(j) Initial Medically Necessary **contact lenses** or glasses required following cataract surgery.

(k) **Contraceptives.** All Food and Drug Administration (FDA) approved contraceptive methods when prescribed by a Physician, including but not limited to intrauterine devices (IUDs) and implants, (including insertion and removal when applicable), injections, and any related Physician and Facility charges including complications. Services will be payable subject to the Preventive Care benefit in the Medical Schedule of Benefits.

Refer to the separate Prescription Drug Benefit of this Plan regarding prescription coverage of oral contraceptive medications, devices, transdermals, vaginal contraceptives, implantables and injectables, including Physician-prescribed over-the-counter (OTC) contraceptives for female Plan Participants.

(l) **Diabetic Education.** Inpatient and outpatient self-management training and education for the treatment of diabetes, provided by a licensed health care professional with expertise in diabetes, will be payable as shown in the Medical Schedule of Benefits.

(m) **Durable Medical Equipment (DME).** Charges for Durable Medical Equipment and supplies necessary for the maintenance and operation of the Durable Medical Equipment that meet all of the following criteria:

- Medically Necessary;
- Prescribed by a Physician for outpatient use;
- Is NOT primarily for the comfort and convenience of the Plan Participant; and
- Does NOT have significant non-medical uses (i.e., air conditioners, air filters, humidifiers, environmental control devices).

If more than one item of Durable Medical Equipment can meet a Plan Participant's needs, Plan benefits are only available for the least cost alternative as determined by the Plan Administrator. Benefits are not available for certain convenience or luxury features that are considered non-standard.

Rental of a Durable Medical Equipment item will be a Covered Charge up to a maximum of the lesser of 24 months or the warranty period of the item, commencing on the date the item is first delivered to the Plan Participant.

A Durable Medical Equipment item may be purchased, rather than rented, with the cost not to exceed the actual acquisition cost of the item to the Plan Participant if the Plan Participant were to purchase the item directly. The acquisition cost of the item may be prorated over a six-month period, subject to prior approval by the Plan Administrator.

Replacement of a Durable Medical Equipment item, rented or purchased, will be a Covered Charge limited to once every four Plan Years.

- Subject to prior approval of the Plan Administrator, replacement for a *purchased* Durable Medical Equipment item may be available for damage beyond repair with normal wear and tear, when repair costs exceed the acquisition cost, or when a change in the Plan Participant's medical condition occurs sooner than the four Plan Year period.

- Subject to prior approval of the Plan Administrator, replacement for a *rented* Durable Medical Equipment item may be available when a change in the Plan Participant's medical condition occurs sooner than the four Plan Year period.

Repair of a Durable Medical Equipment item including the replacement of essential accessories such as hoses, tubing, mouth pieces, etc., are Covered Charges only when necessary to make the item serviceable and the total estimated repair and replacement costs do not exceed the acquisition cost of the item. Rental charges for a temporary replacement Durable Medical Equipment item are Covered Charges up to a maximum of two consecutive months. Requests to repair a Durable Medical Equipment item are not subject to the four Plan Year limit.

The Plan Administrator may require documentation, including but not limited to the make and model number of the Durable Medical Equipment item, the acquisition cost to the provider, and documentation to support Medical Necessity.

Jobst stockings are considered Medically Necessary Durable Medical Equipment when recommended by a Physician.

Note: *Pre-certification is required prior to Durable Medical Equipment that exceeds $2,500* (including all Positive Airway Pressure (PAP) machines and humidifiers regardless of cost). *See the Care Management Services section for more information.*

(n) **Foot Care (Podiatry).** Covered Charges related to foot care include:

- Physician-recommended care and treatment that is the result of infection or as Medically Necessary for treatment of a metabolic or peripheral vascular disease;

- Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet *when surgery is performed;*

- Treatment of corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease;

- Treatment of bunions when an open cutting procedure or arthroscopy is performed, including Physician office visits to diagnose.

Note: See "Orthotic Devices" for coverage of foot orthotics.

(o) ***Genetic Counseling & Testing.*** Genetic counseling is a Covered Charge when a Plan Participant is undergoing approved genetic testing or has an inherited disease and is a potential candidate for genetic testing.

Charges made for genetic testing that use a proven testing method for the identification of genetically-linked inheritable disease will be a Covered Charge for Plan Participants:

- Who have signs or symptoms of a genetically linked inheritable disease;

- Who are at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or

- For whom the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Note: This benefit information does not limit or modify coverage of Genetic Counseling & Testing as specifically outlined by the U.S. Preventive Services Task Force as required coverage through Health Care Reform.

(p) **Home Infusion Therapy.** The Plan will cover home infusion therapy services and supplies when provided by an accredited home infusion therapy agency, which is not a licensed Home Health Agency. These services must be Medically Necessary and are required for the administration of a home infusion therapy regimen when ordered by and are part of a formal written plan prescribed by a Physician. The benefit will include all Medically Necessary services and supplies including the nursing services associated with patient and/or alternative care giver training, visits to monitor intravenous therapy regimen, emergency care, Prescription Drugs, administration of therapy and the collection, analysis and reporting of the results of laboratory testing services required to monitor a response to therapy.

Note: *Pre-certification is required prior to infusion therapy or specialty pharmaceuticals (J-code), to avoid a penalty. See the Care Management Services section for more information.*

(q) ***Infant formula.*** Charges for infant formula, prescribed by a Physician as needed for the treatment of inborn errors of metabolism.

(r) **Infusion Therapy.** Medically Necessary Physician-prescribed administration of fluids, nutrition, or medication by intravenous or gastrointestinal (enteral) infusion or by intravenous injection. Covered Charges under this benefit include Prescription Drugs, nursing and administrative services.

Note: *Pre-certification is required prior to infusion therapy or specialty pharmaceuticals (J-code), to avoid a penalty. See the Care Management Services section for more information.*

(s) **Laboratory studies.** Covered Charges for diagnostic lab testing and services.

(t) **Mental Disorders and Substance Abuse.** Covered Charges will be payable for care, supplies and treatment of Mental Disorders and Substance Abuse.

Note: *Pre-certification is required prior to inpatient admissions or outpatient surgery to avoid a penalty. See the Care Management Services section for more information.*

(u) **Morbid Obesity.** Covered Charges for non-surgical care of Morbid Obesity, limited to Physician office visits, diagnostic testing, and dietary counseling.

Morbid Obesity is defined under this Plan as a serious disease associated with a high incidence of medical complications and a significantly shortened life span. The current clinical standard measure for Morbid Obesity is a BMI (Body Mass Index) of 40+. The BMI is a factor produced by dividing a person's weight (in kilograms) by his/her height squared (in meters).

(v) Injury to or care of **mouth, teeth and gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Repair of Injury incurred to sound natural teeth. Treatment must be initiated within six months from the date of Injury.
- Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Excision and/or removal of soft tissue impacted teeth, bony impacted wisdom teeth, and unerupted impacted teeth, including removal of alveolar bone and sectioning of the tooth and removal of residual root (performed by a Physician (Dentist) other than the one who extracted the tooth).
- *Orthognathic Surgery.* Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
  - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, or disease; or
  - the orthognathic surgery is performed prior to the age of 19 and is required as a result of severe congenital facial deformity or congenital condition.

  Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirement, and there is a high probability of significant additional improvement.

Hospitalization and general anesthesia for dental procedures is considered a Covered Charge for Plan Participants *under age 8,* or a Plan Participant who has a co-morbid medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, or severe cardiovascular disease; or when the Plan Participant is physically or developmentally disabled with a complex dental condition that cannot be safely and effectively treated in a dental office.

Note: *Pre-certification is required prior to inpatient admissions or outpatient surgery to avoid a penalty. See the Care Management Services section for more information.*

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

(w) ***Newborn & Infant Hearing Screening.*** Charges for newborn and infant hearing screening and Medically Necessary follow-up evaluations *(provided in addition to newborn hearing screenings as recommended by the USPSTF),* payable as shown in the Medical Schedule of Benefits. When ordered by a Physician, a newborn's hearing screening must include auditory brainstem responses or evoked otoacoustic emissions or other appropriate technology approved by the FDA.

All screenings shall be conducted by a health care provider acting within the scope of his or her license, preferably one who has training specific to newborn hearing screening. **Newborn means** an age range from birth through 29 days. **Infant means** an age range from 30 days through 12 months.

(x) **Nutritional Education Counseling.** Care, treatment, and services when provided by a health care provider acting within the scope of his or her license, and will be payable as shown in the Medical Schedule of Benefits. This benefit will not include weight loss medications or nutritional supplements whether or not prescribed by a Physician.

(y) **Obesity Interventions.** This benefit is being provided consistent with the Affordable Care Act preventive services requirement. Covered Charges include Physician-directed intensive, multicomponent behavioral interventions for weight management for Plan Participants age 18 and older with a body mass index (BMI) of 30 kg/m^2 or higher.

Intensive, multicomponent behavioral interventions for weight management will include group and individual sessions of high intensity encompassing the following:

- Behavioral management activities such as setting weight loss goals
- Improving diet or nutrition and increasing physical activity
- Addressing barriers to change
- Self-monitoring
- Strategizing how to maintain lifestyle changes

Non-surgical care and treatment and Physician prescribed weight loss medications will not be a covered benefit except as may be specifically described as a benefit by this Plan.

This Plan will not cover gym memberships, or dues for participation in weight loss programs (e.g., Weight Watchers, Jenny Craig, etc.) whether or not prescribed by a Physician.

(z) **Occupational therapy** by a health care provider acting within the scope of his or her license, payable as stated in the Medical Schedule of Benefits. Therapy must be ordered by a Physician, result from an Injury or Illness including autism spectrum disorders, and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

The Plan may require a documented Plan of Care that describes the services being provided and any applicable short term and long term goals, specific treatment techniques, anticipated frequency and duration of treatment, and/or treatment protocol for the Plan Participant's specific condition.

(aa) **Organ transplants.** Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant that is not considered Experimental or Investigational, subject to the following criteria (payable as shown in the Medical Schedule of Benefits):

- The transplant must be performed to replace an organ or tissue.

- Organ transplant benefit period: A period of 365 continuous days beginning five days immediately prior to an approved organ transplant procedure. In the case of a bone marrow transplant, the date the transplant begins will be defined as either the earlier of the date of the beginning of the preparatory regimen (marrow ablation therapy) or the date the marrow/stem cells is/are infused.

- Organ acquisition or procurement. Charges for obtaining donor organs or tissues are Covered Charges under the Plan only when the **recipient** is a Plan Participant. When the donor has medical coverage, *charges for organ acquisition* will pay under the donor's Plan first.

Donor acquisition or procurement includes services for:

(i) Evaluating the organ or tissue;
(ii) Removing the organ or tissue from the donor; and
(iii) Transportation of the organ or tissue from within the United States or Canada to the Facility where the transplant is to be performed.

Note: Expenses related to the purchase of any organ will not be covered.

As soon as reasonably possible, but in no event more than 10 days after a Plan Participant's attending Physician has indicated that the Plan Participant is a potential candidate for a transplant, the Plan Participant or his or her Physician must contact **Pre-certification** at **(877) 573-5745**.

Note: *Pre-certification is required prior to inpatient admissions or outpatient surgery to avoid a penalty. See the Care Management Services section for more information.*

Transplant networks will be used as deemed appropriate by the Plan Sponsor; reimbursement will be based on Tier 1 benefits.

A **Center of Excellence** is a licensed healthcare Facility that has entered into a participation agreement with a national transplant network to provide approved transplant services, at a negotiated rate, to which the Plan has access. A Plan Participant may contact **Pre-certification** to determine whether or not a Facility is considered a Center of Excellence.

Transportation and Lodging

Transportation

When the Plan Participant resides 60 miles or more from the covered transplant Facility, the Plan will reimburse the following reasonable transportation expenses incurred during the transplant benefit period subject to the maximum benefit as specified in the Medical Schedule of Benefits.

Transportation expenses to and from the transplant Facility for the following individuals:

- The Plan Participant and
    - One parent or Legal Guardian of the Plan Participant (only if the Plan Participant is a Dependent minor child); or
    - One adult companion (age 18 or older) to accompany the Plan Participant.

Transportation expenses include commercial transportation (coach class only).

Lodging

When the Plan Participant resides 60 miles or more from the covered transplant Facility, the Plan will reimburse the following reasonable lodging expenses incurred during the transplant benefit period subject to the maximum benefit as specified in the Medical Schedule of Benefits:

- The Plan Participant (if applicable, i.e., if not inpatient); and
    - One parent or Legal Guardian of the Plan Participant (only if the Plan Participant is a Dependent minor child), or
    - One adult companion (age 18 or older) who is accompanying the Plan Participant.

Lodging, for purposes of this Plan, will not include private residences.

Special Transplant Benefits

Under certain circumstances, there may be special transplant benefits available when the group health Plan and/or a Plan Participant participates in a special transplant program and/or contracts with a specific transplant network. Therefore, it is very important to contact **Pre-certification** as soon as reasonably possible so that the Plan can advise the Plan Participant or his or her Physician of the transplant benefits that may be available.

Transplant Exclusions

Coverage for the following procedures, when Medically Necessary, may be provided under the regular Medical Benefits provision under this Plan, subject to all Plan provisions and applicable benefit limitations as stated under this Plan:

- Cornea transplant
- Skin grafts
- Artery
- Vein
- Valve
- Transplantation of blood or blood derivatives (except for bone marrow or stem cells)

(bb) ***Orthotic devices and appliances.*** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints or other appliances used to support, align, prevent, or correct deformities.

Oral orthotic appliances for treatment of obstructive sleep apnea are payable subject to the limits as shown within the Medical Schedule of Benefits. Services must be pre-authorized to determine Medical Necessity. The Plan Participant must submit a request for a pre-authorization of services that includes information from the medical care provider such as patient history, treatment plan, projected outcome, or other criteria that led to this determination. ***This request for pre-authorization is required before any course of treatment begins.*** The Plan Administrator will determine if the proposed treatment will be considered a Covered Charge and will notify the Plan Participant and/or their Physician.

If treatment begins without pre-authorization, or prior to completion of the pre-authorization process, no benefits are payable under the Plan.

Foot orthotics in lieu of surgery for a diagnosed foot condition may be eligible if Medically Necessary.

Coverage of custom foot orthotics is limited to:

- Plan Participants with impaired peripheral sensation and/or altered peripheral circulation (e.g., diabetic neuropathy, peripheral vascular disease);
- Foot orthotics that are an integral part of a leg brace and necessary for the proper functioning of the brace;
- Foot orthotics used as a replacement or substitute for missing parts of the foot (e.g., amputated toes), necessary for the alleviation or correction of Injury, Illness, or a congenital defect; and
- Plan Participants with a neurologic or neuromuscular condition (e.g., cerebral palsy, hemiplegia, spina bifida), producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

Coverage of non-foot orthotics is limited to:

- Rigid and semi-rigid custom fabricated orthotics;
- Semi-rigid prefabricated and flexible orthotics; and
- Rigid prefabricated orthotics including preparation, fitting, and basic additions (such as bars and joints).

Specifically excluded are prefabricated *foot* orthotics, orthotic shoes, shoe additions, modifications, and transfers; orthotics for the purpose of improved athletic performance or sports participation.

(cc) **Physical therapy** by a health care provider acting within the scope of his or her license, payable as shown in the Medical Schedule of Benefits. The therapy must be in accordance with a Physician's exact orders as to type, frequency, and duration for conditions which are subject to significant improvement through short-term therapy. Covered Charges include treatment of autism spectrum disorders.

The Plan may require a documented Plan of Care that describes the services being provided and any applicable short term and long term goals, specific treatment techniques, anticipated frequency and duration of treatment, and/or treatment protocol for the Plan Participant's specific condition.

(dd) **Pre-admission Testing.** Pre-admission testing incurred up to seven days prior to a Hospital admission for non-emergency surgery or treatment will be a Covered Charge **if the following conditions are met:**

- The tests are related to the performance of the scheduled surgery or treatment;
- The tests have been ordered by a Physician after a condition requiring surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital;
- The Plan Participant is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary;
- The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

(ee) **Preventive Care/Routine Well Care.** Covered Charges under Medical Benefits are payable for Preventive Care/Routine Well Care as described in the Medical Schedule of Benefits.

Preventive Care/Routine Well Care is care by a Physician that is not for an Injury or Illness and will only apply in the absence of a diagnosis for a medical condition, including a recurring condition or for medication.

Consult with your Physician at the time services are rendered as to whether or not the services provided will be considered Preventive Care/Routine Well Care as mandated under the Affordable Care Act (ACA), U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations or the Women's Preventive Services as required by the Health Resources and Services Administration (HRSA).

Otherwise, services rendered which are not considered or billed by the Physician as Preventive Care/Routine Well Care (as stated above) will be subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided.

Note: *In addition to the ACA required coverage of preventive/routine x-ray and imaging services (as determined by the USPSTF), the Plan will allow preventive/routine services outside the ACA guidelines under this benefit, when performed by Green Imaging, LLC.*

(ff) **Prosthetic devices.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change. Covered Charges include Medically Necessary repair, maintenance, or replacement of a covered appliance.

Replacement will be provided:

- When necessary due to regular wear;
- When anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy, and/or growth;
- Replacement of any single covered item is limited to no more than once every 12 months for Plan Participants age 18 and under; and no more than once every 24 months for Plan Participants age 19 and over; or
- When necessary due to surgical alteration or revision of the site.

Specifically excluded prosthetic appliances and devices includes: replacement due to abuse or misuse; internal and external power enhancements or power controls for prosthetic limbs and terminal devices; and myoelectric prostheses peripheral nerve stimulators.

(gg) **Reconstructive Surgery.** Covered Charges include reconstructive surgery performed to correct significant deformities caused by congenital or developmental abnormalities, Illness, Injury, and reconstructive mammoplasties.

Mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the Plan Participant.

Note: *Pre-certification is required prior to inpatient admissions or outpatient surgery to avoid a penalty. See the Care Management Services section for more information.*

(hh) **Rehabilitation Services.** Charges for inpatient rehabilitation services are payable as shown in the Medical Schedule of Benefits. Services must be Medically Necessary to restore and/or improve a bodily function that was previously normal but was lost as a result of an accidental Injury, Illness, or surgery.

Services must be furnished in a specialized rehabilitative unit of a Hospital and billed by the Hospital or be furnished and billed by a rehabilitation Facility approved by the Plan. This benefit only covers care the Plan Participant received within 24 months from the onset of the Injury or Illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physiatrist (a Physician specializing in rehabilitative medicine).

Note: *Pre-certification is required prior to inpatient admissions to avoid a penalty. See the Care Management Services section for more information.*

(ii) **Renal Dialysis.** Renal dialysis services include *peritoneal and renal* dialysis, Facility services, supplies and medications provided during treatment, payable as shown in the Medical Schedule of Benefits. Laboratory testing and Physician visits will be payable per normal Plan provisions.

Note: *Pre-certification is required prior to renal dialysis to avoid a penalty. See the Care Management Services section for more information.*

(jj) **Retail Health Clinic.** Covered Charges for limited basic health care services to Plan Participants on a "walk-in" basis at a Retail Health Clinic *(also referred to as a Walk-in Clinic or Convenience Clinic),* payable as shown in the Medical Schedule of Benefits. Retail Health Clinics are normally found in major Pharmacies or retail stores. Health care services are typically received from a Physician's Assistant or Nurse Practitioner for treatment of common Illnesses for adults and children.

(kk) **Sleep Study (sleep disorders).** Services related to the diagnosis and treatment of a Medically Necessary sleep disturbance or disorder.

Note: *Pre-certification is required prior to sleep studies (overnight sleep studies performed at a Facility/sleep Facility), to avoid a penalty. See the Care Management Services section for more information.*

(ll) **Specialty Pharmaceuticals (J-code)** administered under the medical benefits of this Plan (not those received through the Prescription Drug Benefits of this Plan), by or under the direct supervision of a Physician, or under certain conditions, whose administration may initially require Physician oversight but may then be self-administered.

Note: *Pre-certification is required prior to specialty pharmaceuticals (J-code), to avoid a penalty. See the Care Management Services section for more information.*

(mm) **Speech therapy** by a health care provider acting within the scope of his or her license, will be payable as shown in the Medical Schedule of Benefits. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a Plan Participant; (ii) an Injury; (iii) an Illness; or (iv) in treatment of autism spectrum disorders.

The Plan may require a documented Plan of Care that describes the services being provided and any applicable short term and long term goals, specific treatment techniques, anticipated frequency and duration of treatment, and/or treatment protocol for the Plan Participant's specific condition.

(nn) **Spinal Manipulation/Chiropractic Care** by a health care provider acting within the scope of his or her license, payable as shown in the Medical Schedule of Benefits.

(oo) **Sterilization procedures.** Sterilization procedures for female Plan Participants will be payable under the Preventive Care benefit as stated in the Medical Schedule of Benefits.

The following charges will be payable per normal Plan provisions:

- Hysterectomies; and
- Sterilization procedures for male Plan Participants

Note: *Pre-certification is required prior to outpatient surgery to avoid a penalty. See the Care Management Services section for more information.*

(pp) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(qq) **Telehealth.** Physician consultations *other than in person,* i.e., by phone, email, internet, video, or mobile application will be a Covered Charge, payable as shown in the Medical Schedule of Benefits.

To schedule a telehealth appointment through Orlando Health,
call Orlando Health at (855) 549-2235;
or contact them via email at: RVirtualVisit@orlandohealth.com.

(rr) ***Temporomandibular Joint Disorder (TMJ).*** Services for the diagnosis and treatment of, or in connection with, Temporomandibular Joint Disorders or myofascial pain dysfunction.

This benefit includes coverage for mouth guards, splints, or occlusal appliances, ***limited to one appliance every three Plan Years,*** *payable as shown in the Medical Schedule of Benefits.*

If a Physician recommends treatment for or in connection with Temporomandibular Joint Disorders or myofascial pain dysfunction, a Plan Participant must submit a request for a pre-authorization of services that includes the proposed treatment plan, x-rays, and study models, to determine if services will be eligible under the Plan. ***This request for pre-authorization is required before any course of treatment begins.*** The Plan Administrator will determine if the proposed treatment will be considered a Covered Charge and will notify the Plan Participant and/or their Physician.

If treatment begins without pre-authorization, or prior to completion of the pre-authorization process, no benefits are payable under the Plan.

Note: *Pre-certification is required prior to inpatient admissions or outpatient surgery to avoid a penalty. See the Care Management Services section for more information.*

(ss) **Tobacco/Nicotine Cessation Counseling.** Care and treatment for tobacco/nicotine cessation counseling will be payable as shown in the Medical Schedule of Benefits. Refer to the Prescription Drug Benefit section regarding coverage of tobacco/nicotine cessation medications and products.

(tt) **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board, and other normal well-baby care, including circumcision, for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible and enrolled Dependent and a parent (1) is a Plan Participant who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

Covered Charges for routine nursery care will be applied toward the Plan of the newborn child, provided the newborn child is enrolled on a timely basis.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Note: *Pre-certification of a maternity admission that exceeds 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery is required to avoid a penalty. See the Care Management Services section for more information.*

Charges for Routine Physician Care. This benefit is for routine well-baby care made by a Physician for pediatric visits to the newborn child while Hospital confined, including circumcision, as a result of the child's birth.

Covered Charges for routine Physician care will be applied toward the Plan of the newborn child, provided the newborn child is enrolled on a timely basis.

(uu) **Wig.** Charges associated with the purchase of a wig or hairpiece due to hair loss as a result of cancer treatment will be payable as shown in the Medical Schedule of Benefits.

(vv) **X-rays.** Covered Charges for diagnostic x-rays and imaging services.

Green Imaging, LLC, is a direct care network of radiology Facilities offering professional radiology imaging services that includes diagnostic ultrasound, diagnostic radiology imaging, and nuclear cardiology services, payable and subject to the age limit as shown in the Medical Schedule of Benefits. Green Imaging, LLC, schedules Plan Participants for the service they need at a Facility in the Plan Participants' geographic region.

Securely text Green Imaging, LLC at (713) 524-9190, call (844) 968-4647, or initiate chat or web request at www.greenimaging.net to learn more and find the Green Imaging, LLC, location nearest to you. Green Imaging services must be scheduled through its centralized concierge or web app, this Plan does not allow for direct scheduling with its contracted imaging centers. Additionally, this option is only valid for Plan Participants in possession of a valid order for Medically Necessary imaging from a referring Physician.

*In addition to the above diagnostic services, **Green Imaging, LLC**, may also perform preventive/routine x-ray and imaging services, including those that are outside the ACA guidelines of required coverage. Refer to the Preventive Care benefit as shown in the Medical Schedule of Benefits.*

Green Imaging, LLC transportation assistance. *For Plan Participants experiencing transportation issues, Green Imaging, LLC, may offer transportation assistance. The Plan will reimburse Green Imaging, LLC, for the cost of this service; the Plan Participant is not responsible for this expense. Plan Participants in need of transportation assistance need to discuss it with Green Imaging, LLC, at the time they are scheduling their Green Imaging appointment.*

Note: *Pre-certification is required prior to receiving imaging services (MRI, MRA, CT Scan, PET Scan) to avoid a penalty. See the Care Management Services section for more information. Pre-certification is not required if these services are performed through Green Imaging, LLC.*

CLAIM REVIEW AND AUDIT PROGRAM

The Plan has arranged with ELAP Services, LLC ("ELAP") for a program of claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services which are not medically appropriate. Benefits for claims which are selected for review and auditing may be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a usual, customary or reasonable fee determination.

Medical care providers will be given a fully detailed explanation of any charges that are found to be in excess of Allowable Claim Limits, and allowed the rights and privileges to file an appeal of the determination which are the same rights and privileges accorded to Plan Participants; and, in return, the provider must agree not to bill the Plan Participant for charges which were not covered as a result of the claim review and audit. This will in no way affect the rights of the Plan Participant to file an appeal under the Plan. Please refer to the section, "Internal and External Claims Review Procedures" for additional information regarding Plan Participant and provider appeals.

Any Plan Participant who receives a balance-due billing from a medical care provider for these charges should contact ELAP or the Plan Administrator right away for assistance.

The Plan Administrator is identified in the General Plan Information section of this Plan Document and Summary Plan Description. ELAP may be contacted at:

ELAP Services, LLC
1550 Liberty Ridge
Suite 330
Wayne, Pennsylvania 19087
Phone: (610) 321-1030; Fax: (610) 321-1031

The Plan Participant must pay for any normal cost-sharing features of the Plan, such as deductibles, coinsurance and copayments, and any amounts otherwise excluded or limited according to the terms of the Plan.

The success of this program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount of Covered Charges that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the provider of service and the Plan Participant. In the event that the Plan Administrator does not receive information adequate for the claim review and audit within the time limits required under applicable regulations, it will be necessary to deny the claim. Should such a denial be necessary, the Plan Participant and/or the provider of service may appeal the denial in accordance with the provisions which may be found in the section, "Internal and External Claims Review Procedures" in this Plan Document and Summary Plan Description.

In the following provisions of the Claim Review and Audit Program, the term "Plan Administrator" shall be deemed to mean ELAP:

"Allowable Claim Limits" means the charges for services and supplies, listed and included as Covered Charges under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Examples of the determination that a charge is within the Allowable Claim Limit include, but are not limited to, the following guidelines:

(1) **Errors, Unbundled and/or Unsubstantiated Charges**. Allowable Claim Limits will not include the following amounts:

(a) Charges identified as improperly coded, duplicated, unbundled and/or for services not performed;

(b) Charges for treating injuries sustained or illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator can be attributed to medical errors by the provider;

(c) Charges that cannot be identified or understood; and

(d) Charges that cannot be verified from audits of medical records.

(2) Guidelines. The following guidelines will be used when determining Allowable Claim Limits:

(a) Facilities. The Allowable Claim Limit for claims by a Facility, including but not limited to, hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care Facility, shall be the greater of (I) 112% of the Facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. The Allowable Claim Limit for (I) shall not exceed 250% of the federal non-commercial Medicare allowed amount, except for children's hospitals, which shall not exceed 350% of the federal non-commercial Medicare allowed amount. If insufficient information is available to identify either the Facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.

(b) Outpatient Surgical Centers. The Allowable Claim Limit for Outpatient Surgical Centers, including ambulatory surgery centers, which are independent Facilities, shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the Medicare allowed amount, the Allowable Claim Limit for such services shall be to the extent available either the outpatient or inpatient Medicare allowed amount for the service, plus an additional 20%.

(c) Professional Providers. The Allowable Claim Limits for professional providers shall be determined using the following:

(i) For general medical and primary care claims, the Medicare allowed amount in the geographic area plus an additional 40%;

(ii) For specialist medical and surgical care claims, the Medicare allowed amount in the geographic area plus an additional 55%;

(iii) For anesthesiologist claims, the Medicare allowed amount in the geographic area plus an additional 100%;

(iv) For ambulance and air ambulance claims, the Medicare allowed amount in the geographic area plus an additional 20%; or

(v) For other non-Facility claims and supplies (such as, but not limited to, Durable Medical Equipment, laboratory services and supplies, and mid-level providers, etc.), the Medicare allowed amount in the geographic area.

For purposes of determining the proper Allowable Claim Limits for professional providers in categories (i), (ii), (iii), (iv), or (v) above, the Plan Administrator shall determine the applicable category for each claim based on the taxonomy code used by the professional provider for that claim. The Plan Administrator determines in its sole discretion the type of provider for determining Allowable Claim Limits, as detailed above.

While this Plan typically pays professional providers based on the Medicare allowed amounts above, certain services may be reimbursed at 110% of the Medicare allowed amount for the service. These services may include, but are not limited to, routine diagnostic tests, evaluation services, telehealth, and services for ongoing therapy. A full list of services subject to this rule can be found here: www.planlimit.com/prof1. This list will be updated at least annually to reflect the Plan's current plan design.

(d) Directly Contracted Providers. The Allowable Claim Limits for Directly Contracted Providers shall be the negotiated rate as agreed under the Direct Agreement.

(e) **Insufficient Information to Determine Allowable Claim Limit.** In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above as may be applicable, ELAP may apply the following guidelines:

(i) **General Medical and/or Surgical Services.** The Allowable Claim Limit for any covered service may be calculated based upon industry-standard resources including, but not limited to, published and publicly available fee and cost lists and comparisons, or any combination of such resources that in the opinion of the Plan Administrator results in the determination of a reasonable expense under the Plan.

(ii) **Medical and Surgical Supplies, Implants, Devices.** The Allowable Claim Limit for charges for medical and surgical supplies made by a provider may be based upon the invoice price (cost) to the provider, plus an additional 12%. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the Plan Administrator.

(iii) **Physician, Medical and Surgical Care, Laboratory, X-ray, and Therapy.** The Allowable Claim Limit for these services may be determined based upon the 60th percentile of Fair Health (FH®) Allowed Benchmarks.

Comparable Services or Supplies. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above, Allowable Claim Limits will be determined considering the most comparable services or supplies based upon comparative severity and/or geographic area to determine the Allowable Claim Limit. The Plan Administrator reserves the right, in its sole discretion, to determine any Allowable Claim Limit amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Plan Participant.

In the event that a determination of Allowable Claim Limit for a Claim exceeds the actual charges billed for the services and/or supplies, the actual charges billed for the Claim shall be the Allowable Claim Limit.

CARE MANAGEMENT SERVICES

UTILIZATION MANAGEMENT

Utilization Management is a program designed to assist Plan Participants in understanding and becoming involved with their diagnosis and medical Plan of Care, and advocates patient involvement in choosing a medical Plan of Care. Utilization Management begins with the pre-certification process.

MEMBER ADVOCACY PROGRAM

For assistance in identifying the right Provider and to ensure Plan Participants receive quality care in a cost-effective manner, this Plan offers a ***Member Advocacy Program***. This Program is available as no cost to the Plan Participant and provides an opportunity to speak to trained medical professionals who will answer questions and provide information to assist the Plan Participant in making the best decisions regarding their health care needs and treatment options.

When a Plan Participant contacts Member Advocacy and abides by the Member Advocacy recommendation, Covered Charges for the specified services will not be subject to deductible.
***However, coinsurance and/or copayments will continue to apply*.**
This Plan requires referrals to specialty Physicians as stated in the Medical Benefits Schedule.

*Please note that receiving a **Member Advocacy** recommendation does not necessarily mean that all Charges associated with the recommended Facility, Physician, or other healthcare provider are a Covered Charge under the Plan. All claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided.*

Contact the Member Advocacy Program **toll-free at: (844) 297-0747.**
To access the Member Advocacy Program website, visit:
https://mibenefits.ebms.com/auth/login, and select *Health and Services – Member Advocacy.*

PRE-CERTIFICATION REQUIREMENTS

Pre-certification is required by the Plan for the specific services outlined below. Pre-certification provides information regarding coverage before the Plan Participant receives treatment, services and/or supplies. A Pre-certification of services is not a determination by the Plan that a claim will be paid. All claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided.

Pre-certification is required within 24 hours prior to service. Non-compliance with this requirement will result in a **denial of services** per occurrence, applied to Covered Charges billed by the Facility. If there isn't a Facility charge, then the penalty will apply to the primary provider charge. This penalty reduction will not apply toward the maximum out-of-pocket amount.

Pre-certification requirements do not apply to services incurred at The School District of Osceola County Health Center.

HOW PRE-CERTIFICATION WORKS

Before a Plan Participant receives treatment for services included on the pre-certification list, the Plan Participant and/or their attending Physician must contact **Pre-certification** who, in conjunction with the attending Physician, will obtain information for the purpose of pre-certifying the care as appropriate for Plan reimbursement.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

Pre-certification must occur 24 hours in advance of the proposed admission or service. In the case of an inpatient admission directly from the emergency room, notification must occur within 48 hours following the emergency room admission. A maternity admission that does not exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery will not require pre-certification.

SERVICES THAT REQUIRE PRE-CERTIFICATION

- **Inpatient admissions;** to a Hospital, Rehabilitation Facility, Skilled Nursing Facility, or Mental Disorder/Substance Abuse Facility

- **Outpatient surgery** (surgery not performed in a Physician's office)

- **Durable Medical Equipment that exceeds $2,500** (including all Positive Airway Pressure (PAP) machines and humidifiers regardless of cost)

- **Chemotherapy and Radiation Treatment**

- **Infusion Therapy**

- **Specialty Pharmaceuticals (J-code) -** (administered under the medical benefits of this Plan, not those received through the Prescription Drug Benefits of this Plan)

- **Home Health Care**

- **Hospice Care**

- **Imaging Services** - MRI, MRA, CT Scan, PET Scan; *(pre-certification is not required if these services are performed through Green Imaging, LLC)*

- **Renal Dialysis**

- **Pain Management Services** (services not performed in a Physician's office)

- ***Sleep Disorder Studies*** *(overnight sleep studies performed at a Facility/sleep Facility)*

The following information will be requested by **Pre-certification** as part of the pre-certification process:

- The name of the patient and relationship to the covered Employee
- The name, Employee identification number and address of the Plan Participant
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The Plan of Care, treatment protocol and/or informed consent, if applicable

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

Hospital Observation Room stays in excess of 23 hours are considered an admission for purposes of this program, therefore **Pre-certification** should be notified when this occurs.

Pre-certification will determine the number of days of Hospital confinement or use of other listed medical services that may be authorized for payment.

Failure to follow the pre-certification requirements will result in a denial of services per occurrence. This unreimbursed amount will be considered the Plan Participant's responsibility and will not apply toward satisfaction of the Plan Participant's maximum out-of-pocket amount.

Obtaining pre-certification of a particular service does not guarantee that a claim will be reimbursed by the Plan. Benefit payments are subject to the eligibility and other terms, conditions, limitations and exclusions of the Plan in effect at the time services are provided.

The penalty for failure to obtain pre-certification may be reversed in the event a retroactive pre-certification occurs and services are determined to be Medically Necessary. Benefits for services deemed not Medically Necessary or when it is determined that a lesser procedure may be more appropriate, may be reduced or denied.

In the event of an adverse pre-certification determination, the Plan Participant may request a review of that decision in accordance with the "Pre-Notification Determination and Review Process" provision outlined below.

All claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided.

Contact Pre-certification at:
(877) 573-5745

PRE-NOTIFICATION OF SERVICES
(Applies to certain services other than those for which pre-certification is required.)

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Plan Participant receives treatment, services and/or supplies. A benefit determination on a claim will be made only after the claim has been submitted. A pre-notification of services is not a determination by the Plan that a claim will be paid. All claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in this Care Management Services section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures.

PRE-ADMISSION AND POST DISCHARGE CARE CALLS

A **Pre-certification** nurse will contact the Plan Participant to provide health education, pre-surgical counseling, inpatient care coordination, facilitation of discharge plan and post-discharge follow-up.

PRE-NOTIFICATION DETERMINATION AND REVIEW PROCESS

The Plan Administrator or its designee, on the Plan's behalf, will review the submitted information and make a determination on a pre-notification request within 15 days of receipt of the pre-notification request and all supporting documentation. If additional records are necessary to process the pre-notification request, the Plan Administrator or its designee will notify the Plan Participant or the Physician. The time for making a determination on the request will be deferred from the date that the additional information is requested until the date that the information is received.

The Physician and Plan Participant will be provided notice of the Plan's determination. If the pre-notification request is denied, written notice will provide the reason for the adverse pre-notification determination.

As a reminder, a pre-notification of services is not a determination by the Plan that a claim will be paid.

The Plan offers a one-level review procedure for adverse pre-notification determinations. The request for reconsideration must be submitted in writing within 30 days of the receipt of the adverse pre-notification determination and include a statement as to why the Plan Participant disagrees with the adverse pre-notification determination. The Plan Participant may include any additional documentation, medical records, and/or letters from the Plan Participant's treating Physician(s).

The request for reconsideration should be addressed to:

Pre-certification
Attn: Appeals
7410 New LaGrange Road, Ste. 205
Louisville, Kentucky 40222

The Plan Administrator or its designee will perform the reconsideration review. The Plan Administrator or its designee will review the information initially received and any additional information provided by the Plan Participant and determine if the pre-notification determination was appropriate. If the adverse pre-notification determination was based upon the Medical Necessity, the Experimental/Investigational nature of the treatment, service or supply or an equivalent exclusion, the Plan may consult with a health care professional who has the appropriate training and experience in the applicable field of medicine. Written or electronic notice of the determination upon reconsideration will be provided within 30 days of the receipt of the request for reconsideration.

CASE MANAGEMENT

If a Plan Participant has an ongoing medical condition or catastrophic Illness, a Case Manager may be assigned to monitor this Plan Participant, and to work with the attending Physician and Plan Participant to design a treatment plan and coordinate appropriate Medically Necessary care. The Case Manager will consult with the Plan Participant, the family, and the attending Physician in order to assist in coordinating the Plan of Care approved by the Plan Participant's attending Physician and the Plan Participant.

This Plan of Care may include some or all of the following:

- *Provides advocacy for the Plan Participant's care;*
- Individualized support to the patient;
- Contacting the family to offer assistance for coordination of medical care needs;
- Monitoring response to treatment;
- Evaluating outcomes; and
- Assisting in obtaining any necessary equipment and services.

Case Management is not a requirement of the Plan. There are no reductions of benefits or penalties if the Plan Participant and family choose not to participate.

Each treatment plan is individualized to a specific Plan Participant and is not appropriate or recommended for any other patient, even one with the same diagnosis. All treatment and care decisions will be the sole determination of the Plan Participant and the attending Physician.

ALTERNATE COURSE OF TREATMENT

Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long term, or perhaps lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities. If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable benefit maximum(s) set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. A more expensive course of treatment, selected by the Plan Participant or their attending Physician may not be deemed to be Medically Necessary or within Allowable Charge limitations, as those terms are defined by the Plan. The Plan may provide coverage in such circumstances by providing benefits equivalent to those available had the Medically Necessary and otherwise covered course of treatment, subject to the Allowable Charge, been pursued.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Allowable Charge. Except as otherwise set forth herein, Allowable Charge means the amount for a treatment, service, or supply that is (a) the negotiated amount established by a provider agreement, network, arrangement or other discounting or negotiated arrangement; or in the absence of any such arrangement, Allowable Charge means (b) Allowable Claims Limit as determined by the Claim Review and Audit Program.

Note: *Claims for Outpatient Facility renal dialysis charges (not available at SDOC Center for Employee Health, and not performed by a Tier 1/Tier 2 Evolutions Provider) will be considered at the Usual and Customary amount which, at the Plan Administrator's sole discretion, will not exceed 125% of the current Medicare allowable fee for the treatment, supplies, and/or services for the appropriate area as such information is made publicly available.*

In the event the non-Tier 1/non-Tier 2 Provider disputes the Plan's Allowable Charge for any claim subject to the No Surprises Act (NSA) through the Independent Dispute Resolution (IDR) process, the Allowable Charge may be determined by a Certified IDR Entity.

Allowable Claim Limit means the charges for services and supplies, listed and included as Covered Charges under the Plan, which are Medically Necessary for the care and treatment of a covered Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Please refer to the section, "Claim Review and Audit Program" for additional information regarding Allowable Claim Limits.

Birthing Center means any freestanding health Facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This Facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the Facility is located.

The Birthing Center must provide Facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Certified Independent Dispute Resolution (IDR) Entity means an entity responsible for conducting determinations under the No Surprises Act (NSA) that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

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

Complications of Pregnancy are determined as follows:

These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions **are not** considered a Complication of Pregnancy: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning sickness; or like conditions that are not medically termed as Complications of Pregnancy.

Covered Charge means any Medically Necessary item of expense, for which the charge is reasonable and necessary, within Allowable Claim Limits, or is based on the contracted fee schedule of an alternate care delivery system. The Covered Charge will be determined by the Plan Administrator, in its sole discretion.

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

Direct Agreement means a complete agreement between a Directly Contracted Provider and ELAP or the Plan Sponsor which contains the terms and conditions under which the Plan Participants may access discounted fees and/or negotiated or scheduled reimbursement rates which the Plan adopts as Allowable Claims Limits for claims submitted by a Directly Contracted Provider.

Directly Contracted Provider means a medical provider, supplemental benefit provider and/or supplemental network partner which has entered into a Direct Agreement with ELAP, including any affiliates, or the Plan Sponsor to provide certain medical services to Plan Participants at agreed upon Allowable Claim Limits.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means the following:

(1) An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency; and

(2) Within the capabilities of the staff and Facilities available at the Hospital (including Hospital outpatient department that provides emergency services) or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to a Medical Emergency, Emergency Services shall also include an item or service provided by a non-Health Center or non-Tier 1/Tier 2 Evolutions Provider (regardless of the department of the Hospital in which items or services are furnished) after the Plan Participant is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the provider determines that the Plan Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Plan Participant is in a condition to, and in fact does, give informed consent to the provider to be treated as a non-contracted Provider.

Employee means a person who is classified by his Employer as an Active, common law Employee.

Employer is **The School District of Osceola County, FL.**

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

The Plan Administrator must make an independent evaluation of the Experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating Facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) except as provided under the Clinical Trial benefit in the Medical Benefits section of the Covered Charges section, if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating Facility or the protocol(s) of another Facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating Facility or by another Facility studying substantially the same drug, device, medical treatment or procedure.

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

Facility means a healthcare institution which meets all applicable state or local licensure requirements. For the purposes of the Claim Review and Audit Program, Facility includes, but is not limited to, Hospitals, emergency, rehabilitation and Skilled Nursing Facilities, Outpatient Surgical Centers, laboratories, x-ray, MRI or other CT Facilities, and any other health care Facility.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved Generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being Generic.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed Facility, home care, and family counseling during the bereavement period.

Hospice Unit is a Facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and that fully meets these tests: it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic Facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized Facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A Facility operating legally as a psychiatric Hospital or residential treatment Facility for mental health and licensed as such by the state in which the Facility operates.
- A Facility operating primarily for the treatment of Substance Abuse if it has received accreditation from Commission of Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC), or if it meets these tests: maintains permanent and full-time Facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and Facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

Independent Freestanding Emergency Department means a health care Facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services. Independent Freestanding Emergency Departments do not include Urgent Care Centers or Clinics.

Injury means an accidental physical Injury to the body caused by unexpected external means.

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

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the initial period in which the individual is eligible to enroll under the Plan or during a special enrollment period.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the Lifetime of the Plan Participant.

Medical Care Facility means a Hospital, a Facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary or Medical Necessity care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

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

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

Morbid Obesity is a serious disease associated with a high incidence of medical complications and a significantly shortened life span. The current clinical standard measure for Morbid Obesity is a BMI (Body Mass Index) of 40+. The BMI is a factor produced by dividing a person’s weight (in kilograms) by his/her height squared (in meters).

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray Facility, an Outpatient Surgical Center, or the Plan Participant’s home.

Outpatient Surgical Center is a licensed Facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

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

Plan means **The School District of Osceola County Health Services Plan**, which is a benefits plan for certain Employees of **The School District of Osceola County, FL,** and is described in this document.

Plan of Care is a written plan that describes the services being provided and any applicable short term and long term goals, specific treatment techniques, anticipated frequency and duration of treatment, and/or treatment protocol for the Plan Participant's specific condition. The Plan of Care must be written or approved by a Physician and updated as the Plan Participant's condition changes.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on October 1 and ending on the following September 30.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician.

Qualifying Payment Amount (QPA) means the median of the contracted rates recognized by the Plan or recognized by all Plans serviced by the Plan's Third-Party Administrator (if calculated by the Third-Party Administrator), for the same or a similar item or service provided by a provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a QPA, said amount will be determined by referencing an applicable state all-payer claims database or any eligible third-party database in accordance with applicable law.

Recognized Amount, except for non-contracted Provider air ambulance services, means an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable, and for non-contracted Provider air ambulance services, the Recognized Amount shall mean the lesser of a provider's billed charge or the Qualifying Payment Amount.

Skilled Nursing Facility is a Facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24-hour nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, Custodial or educational care.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a Facility referring to itself as an extended care Facility, convalescent nursing home, rehabilitation Hospital, long-term acute care Facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco/nicotine and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Tier 1/Tier 2 Provider means a healthcare institution or healthcare provider who have by contract agreed to provide services at discounted reimbursement rates. A single direct contract or case agreement between a healthcare Facility or healthcare provider, and a Plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Urgent Care Services means care and treatment for an Illness, Injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

Usual and Customary means, for purposes of non-contracted providers outpatient renal dialysis, charges which are identified by the Plan Administrator, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "geographic locale" by providers of similar training and experience for the service or supply.

The term(s) "geographic locale" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services or supplies for which a specific charge is made. To be Usual and Customary, 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 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 term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Plan Participant by a provider of services or supplies, such as a Physician, therapist, nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios as such information is made publicly available, average wholesale price for prescriptions and/or manufacturer's retail pricing for supplies and devices.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Benefits section.

The following is not covered under this Plan:

(1) **Alternative medicine.** Care, treatment, services or supplies related to alternative medicine, including but not limited to acupuncture, holistic medicine, homeopathy, hypnosis, *hyperbaric treatment*, massage therapy, reiki therapy, rolfing, naturopathic care, or other alternative treatment that is not an accepted medical practice as determined by the Plan, except as specifically stated as a benefit under this Plan. Services performed by a Naturopathic Doctor within the scope of his/her license that are otherwise considered a Covered Charge, will be eligible.

(2) **Biofeedback.** Charges for biofeedback.

(3) **Coding guidelines.** Charges for inappropriate coding in accordance with the industry standard guidelines in effect at the time services were received.

(4) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

(5) **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, cosmetic surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by Injury, disease, trauma, congenital/developmental anomalies, or previously covered therapeutic processes.

(6) **Counseling.** Care and treatment for marital or pre-marital, relationship, sexual, or financial counseling.

(7) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance, Custodial Care or domiciliary care consisting chiefly of room and board, except as specifically stated as a Covered Charge under this Plan.

(8) **Dental services.** Care, treatment, services and supplies including appliances in connection with dental services and oral surgery, except as specifically stated as a Covered Charge under this Plan.

(9) **Educational or vocational testing.** Services for educational or vocational testing or training, except as specifically stated as a Covered Charge under this Plan.

(10) **Excess charges.** The part of an expense for care and treatment of an Injury or Illness that is in excess of the Allowable Charge.

(11) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(12) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/ Investigational or not Medically Necessary.

(13) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(14) **Foot care** (routine)**.** Services for routine foot care, *except as specifically stated as a Covered Charge under this Plan.*

(15) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(16) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(17) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except as specifically stated as a benefit under this Plan.

(18) **Hearing Services (routine), and as follows** *(except hearing services specified as a Covered Charge under this Plan):*

- **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting.

- **Implantable Hearing Devices.** Charges for Cochlear Implants, Bone Anchored Hearing Aids (BAHAs), Semi-Implantable Hearing devices, and Audient Bone Conductors.

(19) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or Facility for the service.

(20) **Illegal acts.** Charges for services received as a result of an Illness or Injury occurring directly, or indirectly as a result of a serious criminal act, or a riot or public disturbance, or regardless of causation, if such Illness or Injury occurs in connection with, or while engaged in, or attempting to engage in, a serious criminal act, or a riot or public disturbance. For the purposes of this exclusion, the term "serious criminal act" shall mean any act or series of acts by the Plan Participant, or by the Plan Participant in concert with another or others, for which, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. For this exclusion to apply, it is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed.

Charges for services, supplies, care or treatment to a Plan Participant for an Injury or Illness which occurred as a result of that Plan Participant *voluntarily taking or being under the influence of alcohol or any controlled substance , drug, hallucinogen or narcotic not administered on the advice of a Physician.* Expenses will be covered for other injured Plan Participants not directly related to the potential illegal act, and for expenses for any Plan Participant as related to chemical dependency or substance abuse treatment as specified under this Plan.

This exclusion does not apply if the Injury resulted from being a victim of an act of domestic violence or a medical (including both physical and mental health) condition.

(21) **Impotence.** Care, treatment, services, supplies, *counseling, sexual therapy, implants*, or medication in connection with treatment of impotence or sexual dysfunction; *except dysfunction due to organic disease or gender dysphoria, unless otherwise specified under this Plan*.

(22) **Incarcerated.** Care, treatment, services, and supplies incurred and/or provided to a Plan Participant by a government entity while housed in a governmental institution.

(23) **Infertility.** Charges for impregnation and infertility or fertility treatment; services to restore or enhance fertility, including, but not limited to, artificial insemination, in vitro fertilization, embryo transfer procedures and sterilization reversal. *Services necessary to diagnose infertility and treat the underlying cause of infertility will be considered a Covered Charge, payable per normal Plan provisions*.

(24) **Learning disabilities**, behavioral modifications, or developmental delay services or treatment, except when provided as treatment for an autism spectrum disorder.

(25) **Mailing or Sales Tax.** Charges for mailing, shipping, handling, postage, conveyance, and sales tax.

(26) **Missed Appointment.** Charges for failure to keep a scheduled visit or appointment.

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

(28) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(29) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.

(30) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(31) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as a Covered Charge under this Plan.

(32) **Obesity.** Surgical and non-surgical care and treatment of obesity, surgical treatment of Morbid Obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness, *except obesity screening and counseling as provided consistent with the Affordable Care Act preventive services requirements; and non-surgical treatment of Morbid Obesity, specifically stated as a Covered Charge under this Plan.*

(33) **Occupational Injury.** Care and treatment of an Injury or Illness that is occupational – that is, arises from work for wage or profit including self-employment. This exclusion applies even though the Plan Participant:

(a) Has waived his/her rights to Workers' Compensation benefits;

(b) Was eligible for Workers' Compensation benefits and failed to properly file a claim for such benefits; or

(c) Is permitted to elect not to be covered under Workers' Compensation and has affirmatively made that election.

This exclusion includes services related to an Injury or Illness arising out of or in the course of any professional or semi-professional athletics, including practice.

(34) **Personal comfort items.** Personal comfort items, patient convenience items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-Prescription Drugs and medicines, first-aid supplies and non-Hospital adjustable beds.

(35) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document or that exceed a listed limit under this Plan.

(36) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse.

(37) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(38) **Routine care.** Charges for routine or periodic examinations and evaluation procedures, physical exams and immunizations related to travel, employment, insurance, sports, licensing, etc., or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Illness, or Pregnancy-related condition, which is known or reasonably suspected, except as specifically stated as a benefit under this Plan or required by applicable law.

(39) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(40) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization for men or women.

(41) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically stated as a benefit under this Plan.

(42) **War/Riot.** Any loss that is due to a declared or undeclared act of war, riot, or aggression, *except Plan Participants who are not a member of the armed forces (of any country) who incur Illness or Injury as a victim of any act of war or aggression*.

Claims should be received by the Claims Administrator within 180 days from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within *three years* of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

PRESCRIPTION DRUG BENEFITS

DESIGNATED RETAIL PHARMACY

Designated Retail Pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. **Ventegra** is the administrator of the Pharmacy drug plan.

The Prescription Drug copayment amount (if any) as shown in the Prescription Drug Schedule of Benefits is applied to each covered retail or specialty pharmacy drug charge.

Eligible expenses incurred through a designated Retail Pharmacy apply to the Tier 1/Tier 2 Providers maximum out-of-pocket amount as shown in the Medical Schedule of Benefits.

The following are considered to be a designated Retail Pharmacy under this Plan:

Prescriptions Unlimited Pharmacy
Publix Pharmacy
Walmart Pharmacy

Eligible expenses incurred through a non-designated Retail Pharmacy are not eligible for reimbursement under this Plan, unless specifically provided in the case of an emergency and the Plan Participant is unable to obtain them from a designated Pharmacy or through the School District of Osceola County Center for Employee Health. The Plan Participant will be required to pay 100% of the total cost at the point of sale for the emergency Prescription Drug, no discount will be given, and the Plan Participant will be required to submit the prescription receipt to **Ventegra** for reimbursement up to the amount paid, less any applicable copayment as shown in the Prescription Drug Schedule of Benefits.

Any one retail Pharmacy prescription is available up to a *90*-day supply per prescription.

Plan Participants must present The School District of Osceola County Health Services Plan identification card to one of the designated Pharmacies at the time of purchase. When the Plan Participant does not present their ID card to the Pharmacy at the time of purchase, no reimbursement will occur and the Plan Participant will be required to pay 100% of the total cost at the point of sale. If an emergency situation exists and the ID card is not available at the time of purchase, Plan Participants may submit their Prescription Drug receipt to Ventegra for reimbursement consideration.

SPECIALTY MEDICATIONS

Specialty medications are high-cost injectables, infused, oral, or inhaled medications prescribed in the treatment of chronic and life-threatening diseases including but not limited to: multiple sclerosis, rheumatoid arthritis, Hep C, hemophilia, chronic kidney disease, crohn's disease, or osteoarthritis.

Specialty medications are limited to a 30-day supply per prescription *and are only available when obtained through a designated retail Pharmacy*.

*Please contact **Ventegra** for more information concerning Specialty medications.*

SPECIALTY DRUG ASSISTANCE PROGRAM

This Plan participates in a copayment assistance program referred to as the Benefit Preservation Program (BPP), to assist Plan Participants in obtaining specialty drugs at a lower cost by taking advantage of manufacturer discounts. If the specialty drug is eligible for copayment assistance, the Plan Participant will be contacted by a member of the Benefit Preservation Program who will explain the program and assist the Plan Participant in enrolling, resulting in a lower or sometimes zero copayment. Any copayment amount assessed through this program *will not apply to the Tier 1/Tier 2 maximum out-of-pocket as shown in the Medical Schedule of Benefits.*

Step Therapy Program

Step Therapy is a process that requires the use of one or more first line agents before a medication which is part of a step therapy protocol can be utilized.

The goal of step therapy is to ensure that safe and cost effective medications are used, based on recognized treatment guidelines and well documented clinical studies. This means that in some instances the Plan Participant will need to try one or more medications which are considered first line before he/she is able to receive a "second step" medication through his/her Pharmacy benefit plan.

What happens when a medication is Medically Necessary but it is a part of a Step Therapy protocol? If it is Medically Necessary for the Plan Participant to receive a "second step" medication before any "first step" medications have been tried, the Plan Participant's Physician may request coverage of the medication as a medical exception.

For a complete list of medications that are subject to Step Therapy protocols, contact **Ventegra.**

In addition, there is an alternate resource available to Plan Participants in need of specialty drugs and other higher-cost drugs, through ElectRx. EBMS does not administer any benefits or payments for clients utilizing ElectRx. ElectRx is a different entity in whole and shall be considered such under this health plan document.

For questions, assistance or information regarding the enrollment process, please contact *ElectRx:*
Toll free at: (855) 353-2879
Website: https://www.electrx.com/

Physicians may prepare a prescription for a 30 or 90-day supply with 3 refills and FAX it to ElectRx toll free: (833) 353-2879.

COVERED PRESCRIPTION DRUGS

Note: Some quantity limitations and/or prior authorization may apply.

(1) Drugs prescribed by a Physician that require a prescription either by federal or state law excluding any drugs stated as not covered under this Plan.

(2) Compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other injectable diabetic medications; blood glucose and testing monitors; diabetic supplies such as insulin syringes and needles, and glucose test strips, when prescribed by a Physician.

(4) Injectables, self-injectables, *including non-insulin syringes and needles.*

(5) Acne medications prescribed by a Physician; age 25 and older requires prior authorization .

The following list represents commonly used preventive Prescription Drugs and products required by the Affordable Care Act to be covered at 100%, no copayment required for formulary drugs. Please contact Ventegra for more information regarding preventive Prescription Drugs.

(1) Physician-prescribed contraceptive methods (Food and Drug Administration (FDA) approved) including but not limited to oral contraceptive medications, transdermals, devices (diaphragms, cervical caps, and intra-uterine devices (IUDs)), vaginal contraceptives, implantables, injectables, female condoms, spermicides, and sponges for all female Plan Participants with reproductive capacity.

Refer to the Medical Benefits section of this Plan regarding additional coverage for intrauterine devices (IUDs), implantables, and injectables.

(2) Physician-prescribed tobacco/nicotine cessation medications or products. Physician-prescribed tobacco/nicotine replacement products (such as nicotine patch, gum, lozenges) and Physician-prescribed medications.

(3) Certain vaccinations/immunizations as recommended by applicable federal law.

(4) Additional Physician-prescribed medications as recommended by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations will be covered at 100%, no prescription copayment, coinsurance or deductible will be required.

Please note, the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations may change. Coverage of new recommended medications will be available following the one year anniversary date of the adoption of the USPSTF grade A and B recommendation.

Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact **Ventegra** for more information regarding which medications are available. Note: Age and/or quantity limitations may apply:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results

Limits To This Benefit

This benefit applies only when a Plan Participant incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

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

EXPENSES NOT COVERED

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

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, insulin pumps and pump supplies, artificial appliances, braces, support garments, or any similar device. *These may be considered Covered Charges under the Medical Benefits section of this Plan when deemed Medically Necessary.*

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Plan Participant. This exclusion shall not apply to the extent that charges are for routine patient care associated with an approved clinical trial. (See "Clinical Trials" within the Covered Charges section of this Plan.)

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Immunization.** Immunization agents or biological sera, except as specifically stated as a benefit under this Plan.

(9) **Impotence.** A charge for impotence or sexual dysfunction medication.

(10) **Infertility.** Medications related to fertility/infertility.

(11) **Inpatient medication.** A drug or medicine that is to be taken by the Plan Participant, in whole or in part, while Hospital confined. This includes being confined in any institution that has a Facility for the dispensing of drugs and medicines on its premises.

(12) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(13) **Mail order drugs.**

(14) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(15) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over-the-counter drugs that are prescribed by a Physician and as specifically stated as a Covered Charge under this Plan.

(17) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

HOW TO SUBMIT PHARMACY CLAIMS

For questions on Prescription Drugs contact Ventegra:
Call: (877) 867-0943
Website: https://www.ventegra.com/

HOW TO SUBMIT A CLAIM

When services are received from a health care provider, a Plan Participant should show his or her EBMS/**The School District of Osceola County Health Services Plan** identification card to the provider. Providers may submit claims on a Plan Participant's behalf.

If it is necessary for a Plan Participant to submit a claim, he or she should request an itemized bill which includes procedure (CPT) and diagnostic (ICD) codes from his or her health care provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill
- Group name and number **(The School District of Osceola County Health Services Plan, Group# 00717)**
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

Note: A Plan Participant can obtain a claim form from the Claims Administrator. Claim forms are also available at http://www.ebms.com.

WHERE TO SUBMIT CLAIMS

Claims for expenses should be submitted to the address below:

Evolutions Healthcare Systems
P.O. Box 5001
New Port Richey, Florida 34656

WHEN CLAIMS SHOULD BE FILED

Claims should be received by the Claims Administrator within *180 days* from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be declined.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

A "Claim" means a request for a Plan benefit, made by a Claimant (Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims). A Claim does not include an inquiry on a Claimant's eligibility for benefits, or a request by a Claimant or his Physician for a pre-notification of benefits on a medical treatment. Pre-notification of certain services is strongly recommended, but not required by the Plan. A pre-notification of services is not a determination by the Plan that a Claim will be paid. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification is not required as a condition precedent to paying benefits, and cannot be appealed under this section. Please refer to the Care Management Services section.

A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is not an authorized representative simply by virtue of an assignment of benefits. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives.

There are two types of claims:

Concurrent Care Determination

A **Concurrent Care Determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. If Case Management is appropriate for a Plan Participant, Case Management is not considered a Concurrent Care Determination. Please refer to the Care Management Services section.

Post-Service Claim

A **Post-Service Claim** is a Claim for medical care, treatment, or services that a Claimant has already received.

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about Claims involving specialized medical knowledge or judgment.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

Initial Benefit Determination

The initial benefit determination on a Claim will be made within 30 days of the Claim Administrator's receipt of the Claim (or 15 days if the Claim is a Concurrent Care Determination). If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits.** If additional information is requested, the Plan's time period for making a determination is suspended until such time as the Claimant provides the information, or the end of the 45-day period, whichever occurs earlier. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information. Under the No Surprises Act, the Plan will have up to 30 calendar days to send a notice of denial of payment or an initial payment to the non-contracted Provider from the time the Claim is resubmitted with additional information.

Notice of Adverse Benefit Determination

If a Claim is denied in whole or in part, the Plan shall provide written or electronic notice of the determination that will include the following:

(1) Information to identify the claim involved.

(2) Specific reason(s) for the denial, including the denial code and its meaning.

(3) Reference to the specific Plan provisions on which the denial was based.

(4) Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

(5) Description of the Plan's Internal Appeal Procedures and External Review Procedure and the applicable time limits. This will include a statement of the Claimant's right to bring a civil action once Claimant has exhausted all available internal and external review procedures.

(6) Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

If applicable:

(7) Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim.

(9) Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation or discontinuance because of the Plan Participant's failure to timely pay required premiums.

Claims Review Procedure - General

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level internal review procedure and an external review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by an individual who is neither the individual who made the determination on a prior level of review, nor a subordinate of that individual. Additionally, if an External Review is requested, that review will be conducted by an Independent Review Organization that was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.

- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final Adverse Benefit Determination so that the Claimant has a reasonable amount of time to respond.

- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's Adverse Benefit Determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

Note: When the dispute of a Claim payment or denial only involves payment amounts due from the Plan to the non-contracted Provider, and the provider has no recourse against the Plan Participant under the No Surprises Act, the payment dispute may only be resolved through open negotiation, or the Independent Dispute Resolution (IDR) process as outlined in the NSA. There may be instances when a Plan Participant may appeal a Claim through this section concurrently with a non-contracted Provider's payment dispute through the IDR process.

Internal Appeal Procedure

First Level of Internal Review

The written request for review must be submitted within 180 days of the Claimant's receipt of a Notice of the Initial Benefit Determination (or 15 days for an appeal of a Concurrent Care Determination). The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The appeal should be addressed to:

Plan Administrator
c/o Employee Benefit Management Services, LLC (EBMS)
Attn: Claims Appeals
P.O. Box 21367
Billings, Montana 59104

An appeal will not be deemed submitted until it is received by the Claims Administrator. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The First Level of Internal Review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

Second Level of Internal Review

If the Claimant does not agree with the determination from the First Level of Internal Review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the First Level of Internal Review (or 15 days for an appeal of a Concurrent Care Determination), along with any additional supporting information to:

Plan Administrator
c/o Employee Benefit Management Services, LLC (EBMS)
Attn: Claims Appeals
P.O. Box 21367
Billings, Montana 59104

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The Second Level of Internal Review will be done by the Plan Administrator *and/or its designee*. The Plan Administrator/designee will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator/designee will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

If the Claimant is not satisfied with the outcome of the final determination on the Second Level of Internal Review, the Claimant may request an External Review. The claimant must exhaust both levels of the Internal Review Procedure before requesting an External Review, unless the Plan Administrator/designee did not comply fully with the Plan's Internal Review Procedure for the First Level of Internal Review.

External Review Procedure

This Plan has an External Review Procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within four months from the date of receipt of the notice of the final internal adverse benefit determination or the first day of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a Claim, except where such request is limited by applicable law.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or service is not Medically Necessary.
- Determination that a treatment is Experimental or Investigational.
- Rescission of coverage, whether or not the rescission involved a Claim.
- Violation of cost-sharing and surprise billing protections as identified within the NSA.
- Application of treatment limits to a Claim for a Mental Disorder.

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an External Review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within six business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for External Review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law. **Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within *three years* of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.**

PROVIDER OF SERVICE APPEAL RIGHTS
CLAIM REVIEW AND AUDIT PROGRAM

A Claimant may appoint the provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a Claimant to a provider of service will not constitute appointment of that provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the provider in the same manner as a Claimant's appeal and will respond to the provider and the Claimant with the results of the review accordingly. Any such appeal from a provider of service must be made within the time limits and under the conditions for filing an appeal specified under the section, "Internal and External Claims Review Procedures" above. **Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Charges directly from the Plan, waiving any right to recover such expenses from the Claimant, and comply with the conditions of the section, "Internal and External Claims Review Procedures" above.**

For purposes of this section, the provider's waiver to pursue Covered Charges does not include the following amounts, which will remain the responsibility of the Claimant:

- Deductibles;
- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the Plan;
- Charges for services and supplies which are not included for coverage under the Plan; and
- Amounts which are in excess of any stated Plan maximums or limits. Note: **This does not apply to amounts found to be in excess of Allowable Claim Limits, as defined in the section, "Claim Review and Audit Program".** The provider must agree to waive the right to balance bill for these amounts.

Also, for purposes of this section, if a provider indicates on a Form UB04 or on a CMS – 1500 Form (or similar claim form) that the provider has an assignment of benefits, then the Plan will require no further evidence that benefits are legally assigned to that provider.

Contact the Claims Administrator or the Plan Administrator for additional information regarding provider of service appeal rights.

COORDINATION OF BENEFITS

Coordination of the benefit plans. The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. The Plan has adopted the order of benefits as set forth in the National Association of Insurance Commissioners (NAIC) Model COB Regulations, as amended. When a Plan Participant is covered by this Plan and another plan, or the Plan Participant's Spouse is covered by this Plan and by another plan, or the couple's covered children are covered under two or more plans the plans will coordinate benefits when a claim is received.

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

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or nongroup insurance contracts and subscriber contracts;

(2) Uninsured arrangements of group or group-type coverage;

(3) Group and nongroup coverage through closed panel plans;

(4) Group-type contracts;

(5) The medical components of long-term care contracts, such as skilled nursing care;

(6) Medicare or other government benefits, as permitted by law. This does not include Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan;

(7) The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts;

(8) Any third-party source, including but not limited to, automobile or homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident or non-medical long-term care coverage.

Allowable Charge(s). For a charge to be allowable it must be a usual, customary, and reasonable charge and at least part of it must be covered under this Plan. (See "Allowable Charge" in the Defined Terms section.)

In the case of Health Maintenance Organization (HMO) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Plan Participant does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Plan Participant used the services of an HMO or network provider.

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

Automobile limitations. When any medical benefits coverage is available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge.

The first rule that describes which plan is primary is the rule that applies:

(a) The benefits of the plan which covers the person directly (that is, as an Employee, Retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B"). For Qualified Beneficiaries, coordination is determined based on the person's status prior to the Qualifying Event.

Special rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is Retired), THEN Plan B will pay first.

(b) Unless there is a court decree stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

- The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

- If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

When a child's parents are divorced, legally separated or not living together, whether or not they have ever been married, these rules will apply:

- A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the financially responsible parent has no health care coverage for the Dependent child, but that parent's Spouse does, the plan of that parent's Spouse is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree;

- A court decree may state both parents will be responsible for the Dependent child's health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);

- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

If there is no court decree allocating responsibility for the Dependent child's health care expenses, the order of benefits are as follows:

1st The plan covering the custodial parent,
2nd The plan covering the Spouse of the custodial parent,
3rd The plan covering the non-custodial parent, and
4th The plan covering the Spouse of the non-custodial parent.

When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

Unless specifically stated otherwise, court order and custody provisions apply up to age 19 for any Dependent child.

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a Spouse's plan, Rule (e) applies. If the Dependent child's coverage under the Spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's Spouse.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor Retired or as a Dependent of an Employee who is neither laid off nor Retired are determined before those of a plan which covers that person as a laid-off or Retired Employee. This rule does not apply if Rule (a) can be used to determine the order of benefits. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(d) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor Retired or a Dependent of an Employee who is neither laid off nor Retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (a) can be used to determine the order of benefits.

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

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer and the Plan Participant is enrolled under Part A, Part B, or both, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

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

(5) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Medical Schedule of Benefits. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Plan Participant will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Plan Participant. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

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

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "*Participant(s)*"), or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

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

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

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

Subrogation

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

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

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

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

(1) The responsible party, its insurer, or any other source on behalf of that party;
(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
(3) Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy;
(4) Workers' compensation or other liability insurance company; or
(5) Any other source of Coverage, including, but not limited to, the following:

- Crime victim restitution funds
- Civil restitution funds
- No-fault restitution funds such as vaccine injury compensation funds
- Any medical, applicable disability or other benefit payments
- School insurance coverage

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

Right of Reimbursement

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

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

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

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

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

Participant is a Trustee Over Plan Assets

Any *Participant* who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or accident.

By virtue of this status, the *Participant* understands that he or she is required to:

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

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

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

Release of Liability

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

Excess Insurance

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

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

(1) The responsible party, its insurer, or any other source on behalf of that party.
(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
(3) Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.

(4) Workers' compensation or other liability insurance company.

(5) Any other source of Coverage, including, but not limited to, the following:

- Crime victim restitution funds
- Civil restitution funds
- No-fault restitution funds such as vaccine injury compensation funds
- Any medical, applicable disability or other benefit payments
- School insurance coverage

Separation of Funds

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

Wrongful Death

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

Obligations

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

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

(2) To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.

(3) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.

(4) To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

(5) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

(6) To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been incurred) and/or reimbursement request submitted by or on behalf of the Plan.

(7) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

(8) To not settle or release, without the prior consent of the Plan, any claim to the extent that the *Participant* may have against any responsible party or Coverage.

(9) To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

(10) In circumstances where the *Participant* is not represented by an attorney, instruct the insurance company or any third party from whom the *Participant* obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.

(11) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and *Participant* over settlement funds is resolved.

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

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

Offset

If timely repayment is not made, or the *Participant* and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the *Participant's* amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the *Participant(s)* in an amount equivalent to any outstanding amounts owed by the *Participant* to the Plan. This provision applies even if the *Participant* has disbursed settlement funds.

Minor Status

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

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

Language Interpretation

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

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

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

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA.

Domestic Partners and their Dependents are not considered "Qualified Beneficiaries" under COBRA Continuation Rights under Federal Law. However, this Plan has chosen to allow a covered Employee's Domestic Partner and their Dependent children who otherwise satisfy the Eligibility requirements set forth in the Eligibility provision of this Plan and who are active Plan Participants, the opportunity to make an independent election to receive COBRA Continuation Coverage. All references to Spouse will also be applicable to a Domestic Partner, unless otherwise indicated.

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee's hours of employment are reduced;
- The parent – covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent – covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a "Dependent child."

If this Plan provides Retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The Retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

Plan Administrator
The School District of Osceola County, FL
Risk and Benefits Management
817 Bill Beck Boulevard
Kissimmee, Florida 34744
(407) 870-4899

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their Dependent children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

Medicare extension of COBRA Continuation Coverage

If you (as the covered Employee) become entitled to Medicare benefits, your Spouse and Dependents may be entitled to an extension of the 18-month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination of employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and Dependent children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18-month period.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator as set forth herein, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
The School District of Osceola County, FL
Risk and Benefits Management
817 Bill Beck Boulevard
Kissimmee, Florida 34744
(407) 870-4899

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
The School District of Osceola County, FL
Risk and Benefits Management
817 Bill Beck Boulevard
Kissimmee, Florida 34744
(407) 870-4899

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage will end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;

- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;

- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;

- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or

- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.HealthCare.gov.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the COBRA Administrator:

PLAN ADMINISTRATOR
The School District of Osceola County, FL
Risk and Benefits Management
817 Bill Beck Boulevard
Kissimmee, Florida 34744
(407) 870-4899

COBRA ADMINISTRATOR
UnifyHR
P.O. Box 6763
Fargo, North Dakota 58108-6763
(800) 519-8366
COBRA@unifyhr.com

For more information about your rights under the *Public Health Services Act*, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The School District of Osceola County Health Services Plan is the benefit plan of **The School District of Osceola County, FL,** the Plan Administrator, also called the Plan Sponsor. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

Notwithstanding any provisions of this Plan Document and Summary Plan Description to the contrary, the Plan Sponsor has the authority to, and hereby does, allocate certain responsibility to ELAP Services, LLC ("ELAP"). The responsibility allocated to ELAP is limited to discretionary authority and decision-making authority with respect to the review and audit of certain claims in accordance with the applicable Plan provisions under the section, "Claim Review and Audit Program". Such claims selected as eligible for review and audit shall be identified by ELAP under guidelines to which the Plan Sponsor has agreed, and shall be referred to ELAP by the Plan Administrator. *The Plan Sponsor has allocated additional fiduciary responsibility to ELAP, limited to discretionary authority and decision-making authority with respect to appeals of denied claims, which shall be referred to ELAP by the Plan Administrator (the "Referred Appeals"). ELAP shall have no authority, responsibility, or liability other than with respect to the Referred Appeals and its duties under the Claim Review and Audit Program.*

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

DUTIES OF THE PLAN ADMINISTRATOR

The duties of the Plan Administrator include the following:

(1) To administer the Plan in accordance with its terms;
(2) To determine all questions of eligibility, status and coverage under the Plan;
(3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
(4) To make factual findings;
(5) To decide disputes which may arise relative to a Plan Participant's rights;
(6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
(7) To keep and maintain the Plan documents and all other records pertaining to the Plan;
(8) To appoint and supervise a third party administrator to pay claims;
(9) To establish and communicate procedures to determine whether a medical child support order or national medical support notice is a QMCSO;
(10) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
(11) To perform each and every function necessary for or related to the Plan's administration.

DUTIES OF ELAP

ELAP shall have the following duties with respect to the Claim Review and Audit Program:

(1) To administer the Plan in accordance with its terms;
(2) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
(3) To make factual findings;

(4) To decide disputes which may arise relative to a Plan Participant's rights and negotiating settlements, if appropriate;
(5) To review appeals of claims under the Claim Review and Audit Program, and to uphold or reverse any denials;
(6) To review Referred Appeals and to uphold or reverse any denials;
(7) To perform the duties in conjunction with the provisions of the Claim Review and Audit Program;
(8) To keep and maintain records pertaining to the Claim Review and Audit Program; and
(9) To keep and maintain records pertaining to the Referred Appeals.

The duties of ELAP shall be limited to those set forth above.

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

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

For Dependent Coverage: Funding is derived from the funds of the covered Employee.

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

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

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

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

DISTRIBUTION OF ASSETS

In the event of a termination or partial termination of the Plan or Trust (if applicable), The School District of Osceola County, FL, by action of its Board of Directors or an authorized committee thereof, shall direct the disposition of Plan assets, including assets held in a Trust, if any, which may include transfer of such assets to another employee benefit plan or trust maintained by an Employer.

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

"Protected Health Information" (PHI) means individually identifiable health information, created or received by a health care provider, health plan, Employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

(2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

(7) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

(a) The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Director of Risk and Benefits
Employee Benefits Supervisor

(b) The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

(c) In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "SECURITY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

(4) Report to the Plan any security incident of which it becomes aware.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

The School District of Osceola County Health Services Plan

PLAN NUMBER: Not Applicable

TAX ID NUMBER: 59-6000779

PLAN EFFECTIVE DATE: January 10, 1984

PLAN YEAR ENDS: September 30

EMPLOYER INFORMATION

The School District of Osceola County, FL
817 Bill Beck Boulevard
Kissimmee, Florida 34744
(407) 870-4899

PLAN ADMINISTRATOR

The School District of Osceola County, FL
817 Bill Beck Boulevard
Kissimmee, Florida 34744
(407) 870-4899

CLAIMS ADMINISTRATOR

Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, Montana 59104
(800) 777-3575 or (406) 245-3575

Plan Name: **The School District of Osceola County Health Services Plan**

Original Effective Date: **January 10, 1984**

Plan Option: **Health Center Benefit Plan Option**

Plan Option Effective Date: **October 1, 2024**

I, H. Kahoun (Name), certify that I am the Board Chair (Title) of the **Plan Administrator** for the above named Plan, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the terms described herein and am hereby authorizing the implementation of the Plan as of the effective date noted above.

Signature: H. Kah

Print Name: H. Kahoun

Date: 10/22/24