FRIENDS MUTUAL HEALTH GROUP PLAN

Summary Plan Description

$1,500 Deductible Plan

Revised Jan. 1, 2021

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Schedule of Benefits

Medical benefits under the Friends Mutual Health Group Plan are provided through the Highmark Blue Shield Preferred Provider Organization (PPO) Program. It is your responsibility to make sure that a health care provider is a network provider before medical treatment is received. The health care provider that you select can assist with this information. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care.

This page lists the schedule of benefits that applies to the group health coverage provided by the plan. It is only a summary of plan benefits. See *Part IX* for specific information and complete details about the benefits covered under this plan.

Employer Requirements	
Member organization	Foxdale Village
Minimum employment requirement	Average of 30 hours per week pursuant to the Foxdale Village Policy and Procedure HR 300 – Eligibility for Health Coverage under the Affordable Care Act (Eligibility Policy), attached to this summary plan description
Family members eligible for coverage	Spouse or domestic partner and children up to age 26
Employee eligibility waiting period	0 days
Beginning date of coverage: • New employee • Increase in hours of employment	 As outlined in Foxdale Village Eligibility Policy As outlined in Foxdale Village Eligibility Policy
Ending date of coverage: • Termination of employment • Reduction in hours of employment	 Last day of month in which employment terminates As outlined in Foxdale Village Eligibility Policy

Plan Requirements	**In-Network**	**Out-of-Network**
Calendar-year deductible	$1,500 per person; $3,000 per family.	$3,000 per person; $6,000 per family.
Calendar-year coinsurance	You pay 20% of next $10,000 per person; you pay 20% of next $20,000 per family.	You pay 50% of next $10,000 per person; you pay 50% of next $20,000 per family.
Annual out-of-pocket maximum for deductible and coinsurance	$3,500 per person; $7,000 per family.	$8,000 per person; $16,000 per family.
Total annual out-of-pocket maximum (deductible; coinsurance; office visit, Amwell, emergency room & prescription drug copays)	$8,550 per person; $17,100 per family.	$8,000 per person; $16,000 per family.
Lifetime maximum benefit for assisted fertilization services	• Medical services – $10,000 for each covered person • Prescription drugs – $3,000 for each covered person	
Precertification	You are responsible to contact Highmark Health Care Management Services 7-10 days prior to a planned inpatient admission or within 48 hours of an emergency admission.	
Filing claims	PPO provider files claims.	You are responsible to file claims.

Plan Benefits	**In-Network**	**Out-of-Network[1]**
Inpatient Facility Services		
• Hospital services[2]	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.
• Skilled nursing facility care[2], up to 100 days per calendar year	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.
Outpatient Services		
• Primary care physician office visit charge • Specialist office visit charge • Urgent care facility office visit charge	• You pay $50 office visit copay. • You pay $75 office visit copay. • You pay $75 office visit copay.	You pay out-of-network deductible and coinsurance.
• Amwell virtual physician visits	You pay $49 copay.	No plan benefit outside of Amwell network of physicians.
• Physician/specialist/urgent care facility services other than office visit charge • Chemotherapy, radiation therapy, and kidney dialysis • Maternity care (physician fees) • Home health care • Health education programs • Medical supplies and equipment • Cardiac rehabilitation programs • Durable medical equipment, orthotics, and prosthetics • Outpatient surgery in hospital, outpatient surgical center, or physician office • X-ray, lab, and diagnostic services • Spinal manipulations, up to 12 visits per year • Physical medicine, speech therapy, and occupational therapy, up to a combined limit of 36 visits per year (includes acupuncture) • Infertility counseling, testing, and treatment • Assisted fertilization (medical services)	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.
• Allergy testing and shots • Enteral formulae	You pay in-network coinsurance.	You pay out-of-network coinsurance.

Plan Benefits (cont.)	In-Network	Out-of-Network[1]
Outpatient Services (cont.)		
• Home infusion therapy • Private duty nursing • Respiratory therapy • Acupuncture, up to a combined limit of 36 visits per year (includes physical medicine, speech therapy, and occupational therapy)	You pay in-network deductible and coinsurance.	
Emergency Services		
• Ambulance	You pay in-network deductible and coinsurance.	
Hospital emergency room care: • Facility charges • Other services billed separately by emergency room providers	• If admitted to hospital, you pay in-network deductible and coinsurance. • If not admitted to hospital, you pay $250 copay – no deductible or coinsurance. • You pay in-network deductible and coinsurance.	
Adult Preventive Care Services[3]		
• Routine physical exams and screenings • Well-woman visits to obtain preventive services • As prescribed, FDA-approved contraceptive methods (including sterilization) for all women with reproductive capacity • Preventive care services, screenings and procedures for pregnant women • Breastfeeding (lactation) counseling and support, including costs of breastfeeding equipment • Routine gynecological exam and pap test • Mammograms – routine screening • Routine prostate specific antigen test and/or digital rectal exam • Services for prevention of obesity, heart disease, and diabetes • Routine adult immunizations	Plan pays 100%.	Not covered.
Pediatric Preventive Care Services[3]		
• Routine physical exams and screenings • Routine pediatric immunizations • Services for prevention of obesity and heart disease	Plan pays 100%.	Not covered.
Hospice Services		
• Inpatient services[2] • Outpatient services	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.
Mental Health Services		
• Inpatient services[2] • Outpatient services	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.
Substance Abuse Services		
• Inpatient detoxification[2] • Inpatient rehabilitation[2] • Outpatient treatment	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.

[1]Plan payments for services received from an out-of-network provider are based on the allowable charge for the type of care, service, or treatment received. If the provider's charges are more than the allowable charge, you will be responsible for paying the difference. Any of these extra amounts you have to pay will not count toward your calendar-year deductible and coinsurance requirements or total annual out-of-pocket maximum.

[2]Precertification required. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

[3]The schedule of covered preventive services is outlined in Highmark's *Preventive Schedule* and *Women's Health Preventive Schedule*, which are updated periodically based on changes in clinical practice guidelines.

Outpatient Prescription Drug Benefit[4] – Administered by CVS Caremark	
Tier 1 Generic drugs[5]: • Retail drugs purchased at a participating pharmacy • Maintenance drugs purchased at a CVS retail pharmacy • Maintenance drugs through mail order	 • You pay 10% copay[6], up to 30-day supply. • You pay 10% copay[6], 90-day supply. • You pay 10% copay[6], up to 90-day supply.
Tier 2 Preferred brand-name drugs on the Preferred Drug List: • Retail drugs purchased at a participating pharmacy • Maintenance drugs purchased at a CVS retail pharmacy • Maintenance drugs through mail order	 • You pay 30% copay[6], up to 30-day supply. • You pay 30% copay[6], 90-day supply. • You pay 30% copay[6], up to 90-day supply.
Tier 3 All other brand-name drugs: • Retail drugs purchased at a participating pharmacy • Maintenance drugs purchased at a CVS retail pharmacy • Maintenance drugs through mail order	 • You pay 50% copay[6], up to 30-day supply. • You pay 50% copay[6], 90-day supply. • You pay 50% copay[6], up to 90-day supply.
Tier 4 Specialty pharmaceuticals purchased from a Caremark specialty pharmacy as directed by CVS Caremark	You pay 30% copay[6], up to 30-day supply

[4]Prior authorization required for compound drugs costing $300 or more, any drug costing $5,000 or more, and all specialty pharmaceuticals.

[5]Mandatory generic when available.

[6]Copays for outpatient prescription drugs are not counted toward meeting your calendar-year deductible and coinsurance requirements.

Part I, Introduction

This summary plan description describes the medical benefits provided by the Friends Mutual Health Group Plan for eligible employees of member organizations and their qualified dependents. The summary plan description will tell you how you can be covered by the plan, how to file a claim, and other important information about how the plan works. Please read it carefully.

If you have questions about the plan or about points in the plan that aren't covered in the summary plan description, please talk to the ***plan representative***. His or her name is listed in *Part XXI*.

Claims for the plan will be handled by a claims administrator who is trained in the benefits offered by the plan. The claim administrator's name, address, and phone number are:

Highmark Blue Shield (Highmark)
P.O. Box 1210
Pittsburgh, PA 15230-1210
(800) 226-2239

Part II, Definitions

The following words and terms are used in this summary plan description. When used, this is what they mean:

Allowable charge — The dollar amount that Highmark has determined is reasonable for covered services provided under this plan. The amount the plan pays for covered services is based on the allowable charge, not the provider's actual charge.

Ambulatory surgical facility — A licensed public or private establishment that:
1. Has an organized medical staff of physicians;
2. Has permanent facilities to provide chiefly elective surgical care, continuous physician services, and nursing services;
3. Is properly licensed by all applicable regulatory agencies;
4. Maintains medical records for each patient;
5. Does not have facilities for patients to stay overnight; and
6. Does not exist for the purpose of terminating pregnancies.

Amwell — A program provided through Highmark to members that offers 24/7/365 (on demand) access from any location in the U.S. to a national network of physicians and pediatricians who provide virtual medical consultations to treat non-emergency conditions via telephone, computer, or mobile applications (iPhone, iPad, etc.).

Ancillary provider — Includes the following:
1. Ambulance service,
2. Clinical laboratory,
3. Diabetes prevention provider,
4. Home infusion therapy provider,
5. Independent diagnostic testing facility (IDTF),
6. Suite infusion therapy provider, and
7. Suppliers.

Calendar year — The 12-month period from Jan. 1 through Dec. 31 of any year.

Claim — A request for precertification or other approval of a covered service, or a request for payment or reimbursement of the charges or costs associated with a covered service. Claim includes the following:
1. Pre-service claim – A request for precertification or prior approval of a covered service which, under the terms of the plan, must be approved in advance of obtaining medical care.
2. Post-service claim – A request for payment or reimbursement of the charges or costs associated with a covered service a member has received.
3. Urgent Care claim – A pre-service claim where failing to make a determination quickly could seriously jeopardize an individual's life, health, or ability to regain maximum function, or, in the opinion of a physician with knowledge of the individual's medical condition, would subject the individual to severe pain that could not

be managed without the requested treatment. Any claim that a physician with knowledge of an individual's condition considers an urgent care claim becomes an urgent care claim.

Coinsurance — The specific percentage of allowable charges for certain eligible expenses you and the plan share after the deductible requirement is met.

Complications of pregnancy — Includes the following:
1. Conditions requiring medical treatment before or after the termination of pregnancy whose diagnoses are distinct from pregnancy, but which are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis; cardiac decompensation; missed abortion; disease of the vascular, hematopoietic, nervous, or endocrine systems; and similar medical and surgical conditions of comparable severity;
2. Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible;
3. An emergency or non-scheduled cesarean section; and
4. Treatment to stop premature labor and birth.

Contracting suppliers (for the sale or lease of) — Include, but are not limited to:
1. Durable medical equipment,
2. Supplies,
3. Orthotics, and
4. Prosthetics.

Copayment — A specific dollar amount you are required to pay to the provider each time a particular type of treatment or service is rendered. Office visit, Amwell virtual physician visit, emergency room, and prescription drug copayments do not count toward meeting your deductible and coinsurance requirements but do count toward meeting your total annual out-of-pocket maximum.

Creditable coverage — Includes coverage under any of the following:
1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10, United States Code;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5, United States Code;
9. A public health plan established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); and
11. Title XXI of the Social Security Act, State Children's Health Insurance Program (S-CHIP).

Creditable coverage does not include:
1. Coverage only for accident or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics; and
8. Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Custodial care — Any type of service that is designed to assist you or your covered dependent, whether disabled or not, in the activities of daily living. Such services include assistance in walking or getting in and out of bed, bathing, dressing, feeding, preparation of special diets, and supervision over medication that can normally be self-administered.

Deductible — The specific dollar amount you or your covered dependent must pay for eligible expenses each calendar year before benefits are payable, in whole or in part, under this plan.

Diabetes education program — An outpatient program of self-management, training, and education (including medical nutrition therapy) for the treatment of diabetes. The program must be conducted under the supervision of a licensed health care professional with expertise in diabetes.

Diabetes prevention program — A 12-month program using curriculum approved by the Centers for Disease Control to deliver a prevention lifestyle intervention for those at high risk of developing type 2 diabetes. The program includes behavioral and motivational content focusing on moderate changes in both diet and physical activity.

Diabetes prevention provider — An entity that offers a diabetes prevention program based on an in-person/onsite or digital model and that has an agreement with Highmark. If the program is based on an in-person/onsite model, the program must offer services through a participating member association which has a contract with the YMCA.

Domestic partner — A member of a domestic partnership consisting of two partners of the same or opposite gender. The domestic partner of an employee is eligible to be covered under the plan only when coverage for domestic partners is provided by the member organization, as indicated in the *Schedule of Benefits*. The domestic partner of an employee of a member organization that does not provide coverage for domestic partners is not eligible to be covered under the plan.

Domestic partnership — A voluntary relationship between two domestic partners.

Elective surgery — A covered surgery that may be deferred and is not an emergency.

Emergency — A medical condition manifesting itself (including injuries) by acute signs or symptoms that could reasonably result in placing a covered person's life or limb in danger if immediate medical attention is not provided.

Employee — Any person who is employed and compensated for services by a member organization (as outlined in *Part III*) in a legal employer-employee relationship, is a common-law employee of the member organization, and is on the member organization's W-2 payroll. For purposes of this plan, the term "employee" does not include leased employees, independent contractors, or self-employed individuals, whether or not any such persons are on the member organization's W-2 payroll.

Employee eligibility waiting period — The specific amount of time an employee who is determined by the member organization to be a full-time employee pursuant to the member organization's Eligibility Policy must be employed by the member organization before the employee and his or her dependents are eligible to enroll in the plan, as outlined in the member organization's Eligibility Policy. The employee eligibility wait period, if required by the member organization, is listed in the *Schedule of Benefits*.

Enteral formulae — A liquid source of nutrition administered under the direction of a physician that is administered into the gastrointestinal tract either orally or through a tube and which may contain some or all of the nutrients necessary to meet minimum daily nutritional requirements. Enteral formulae is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are identified through medical evaluation.

Experimental or investigative medical treatment — Any treatment, service, procedure, facility, equipment, drug, device, or supply (intervention) that is not determined by Highmark to be medically effective for the condition being treated. An intervention is considered to be experimental or investigative if:

1. The intervention does not have approval from the U.S. Food and Drug Administration (FDA) to be marketed for the specific relevant indication(s);
2. Available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes;
3. The intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies;
4. The intervention does not improve health outcomes; or
5. The intervention is not proven to be applicable outside the research setting.

If an intervention, as identified above, is determined to be experimental or investigative at the time the service is rendered, it will not receive retroactive coverage, even if it is found to no longer be experimental or investigative within the above criteria at a later date.

Highmark recognizes that situations may occur when you elect to pursue experimental or investigative treatment. If you are planning to receive a service that Highmark may consider to be experimental or investigative, you, the

hospital, or the professional provider may contact Highmark Member Service to determine whether Highmark considers the service to be experimental or investigative.

Facility provider — A health care institution or service that is approved by Highmark and is licensed to render health care services authorized by Highmark. Facility providers include the following:
1. Ambulatory surgical facility,
2. Birthing facility,
3. Day/night psychiatric facility,
4. Freestanding dialysis facility,
5. Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility,
6. Home health care agency,
7. Hospice,
8. Hospital,
9. Outpatient physical rehabilitation facility,
10. Outpatient psychiatric facility,
11. Outpatient substance abuse treatment facility,
12. Pharmacy provider,
13. Psychiatric hospital,
14. Rehabilitation hospital,
15. Residential treatment facility,
16. Skilled nursing facility,
17. Substance abuse treatment facility, and
18. Urgent care facility.

Full-time employee — An employee who is employed an average of at least 30 hours of service per week with the member organization, pursuant to the member organization's Eligibility Policy for determining full-time employee status under Internal Revenue Code §4980H, which is attached to this summary plan description.

Home health care agency — An agency that specializes in giving nursing and other therapeutic services in the home. The home health care agency provides services prescribed by the covered person's attending physician in a formal treatment plan for the individual's care. The agency must be approved as such by the state in which it is located, have a full-time administrator, and maintain a complete record on each individual.

Hospice care agency — An agency that provides counseling, medical services, and room and board to individuals and their families during the final stages of a terminal illness and during bereavement. A hospice care agency must:
1. Be licensed as such by the state in which it is located;
2. Provide services 24 hours a day, seven days a week;
3. Exist mainly to provide hospice services;
4. Be directly supervised by a physician;
5. Have a full-time administrator, a licensed social service coordinator, and a registered nurse coordinator; and
6. Maintain written records of its services provided to the patient.

Hospital — A legally operating institution that:
1. Provides — for a fee — diagnostic, medical, and surgical care and treatment of ill or injured persons;
2. Has a staff of one or more physicians on call at all times;
3. Provides 24-hour nursing services under the full-time supervision of a registered nurse (R.N.);
4. Has inpatient facilities; and
5. Is accredited as a hospital by the Joint Commission, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities.

The term *hospital* **does not** include a clinic, rest home, extended care facility, convalescent nursing home, home for the aged, or a place that provides chiefly custodial care.

Illness — A physical or mental disorder or infirmity that interferes with normal bodily functions. It includes pregnancy and pregnancy-related conditions. It does not include any condition a member develops as the result of work for wage or profit and which is covered by Workers' Compensation.

Immediate family — A member's spouse or domestic partner, child, parent, sibling, or in-law.

Infertility — The presence of a demonstrated condition recognized by a licensed physician or surgeon that prevents conception or carrying a pregnancy to term. The inability to conceive may be due to either the male or female partner.

Injury — Bodily damage caused by accidental, unexpected, external means while this plan is in effect. It does not include injuries a member receives in connection with his or her job or any other occupation for which the member is paid (including self-employment).

Medically necessary and appropriate — Services, supplies, or covered medications that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluation, diagnosing, or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

Highmark reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply, or covered medication is medically necessary and appropriate. No benefits will be provided under this plan unless Highmark determines that the service, supply, or covered medication is medically necessary and appropriate.

Member — Any employee or dependent who meets all applicable eligibility requirements, as outlined in *Part III*, and is enrolled in and receiving benefits under this plan.

***Member organization* —** A Friends organization who meets the eligibility criteria listed below, is eligible to receive church plan designation by the Internal Revenue Service, and is enrolled in and participating in the plan:

1. A recognized yearly meeting, quarterly meeting, monthly meeting, or church of the Religious Society of Friends in the U.S.;
2. A Quaker organization in the U.S.;
3. A recognized regional or national Friends association (e.g. Friends Services for the Aging, Friends Council on Education, Friends Association for Higher Education, etc.); or
4. A member of a recognized regional or national Friends association (e.g. Friends Services for the Aging, Friends Council on Education, Friends Association for Higher Education, etc.).

Mental illness — A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind that is generally believed in the medical community to be treatable.

National BlueCard® Preferred Provider Organization (PPO) Network — A network of physicians, hospital or facility providers, professional providers, and other health professionals or facilities that have contracted to provide covered medical, mental health, or substance abuse treatment, services, and supplies at negotiated fees under the Highmark Blue Shield Preferred Provider Organization Program.

Network provider — An ancillary provider, professional provider, or facility provider furnishing medical services and supplies as part of the Highmark Blue Shield Preferred Provider Organization (PPO) Program. Eligible network providers include facilities, general practitioners, internists, obstetricians/gynecologists, and a wide range of specialists.

You may call (800) 810-BLUE (2583) or go to the Blue Shield website at www.highmarkblueshield.com, choose the "Find a Doctor or Rx" tab and click on "Find a doctor, hospital or other medical provider" to locate the network provider nearest you or to verify that your current provider is in the network.

Using a network provider when receiving medical treatment, services, or supplies assures that members receive maximum benefits under this plan.

Other coverage — The amount of any benefits paid or value received from other insurance or benefit plans for the same loss.

Partial hospitalization — A distinct and organized intensive ambulatory treatment service. It is less than 24-hour daily care specifically designed for the diagnosis and active treatment of an individual's mental illness or substance abuse (as defined in this document) when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization. It may include day, night, evening, or weekend care. This intensive ambulatory psychiatric treatment includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational treatment modalities usually found in a comprehensive hospital program. Partial

hospitalization may include group and family therapies, individual therapy, pharmacotherapy, psychodrama, and occupational/recreational therapies in a distinct, structured therapeutic environment. Partial hospitalization operates in a hospital, is medically supervised, and is at least three hours in duration per patient visit. Admission to or release from partial hospitalization must be approved by a qualified physician.

Physical medicine — When prescribed by a physician, the medically necessary and appropriate outpatient treatment of illness or injury by physical agents such as heat, cold, light, electricity, or the use of mechanical devices. The intention of treatment is restoration or maintenance, not enhancement, of bodily function. Physical medicine includes, but is not limited to:
1. Physical therapy,
2. Cognitive therapies,
3. Biofeedback, and
4. Sports medicine.

Physical medicine does not include:
1. Membership fees for exercise facilities and health spas;
2. Payment for exercise-type equipment;
3. Spinal manipulations; or
4. Treatment programs not administered by a professional provider.

Physician (doctor) — A person legally qualified and licensed to practice medicine or osteopathy. This definition does not include you, a member of your immediate family, or co-workers.

Plan — The Friends Mutual Health Group Plan for eligible employees of member organizations and their qualified dependents, as set forth in this summary plan description and as amended from time to time.

Plan administrator — The person or entity that maintains the records of the plan, administers the plan, has discretionary authority to interpret the provisions of the plan, and makes all decisions necessary or proper to carry out the terms of the plan. The plan administrator may delegate its responsibilities to other persons or entities. The plan administrator for this plan is the Friends Mutual Health Group (FMHG).

Plan year — The plan's fiscal year. It is the 12-month period beginning each Jan. 1 and ending the following Dec. 31.

Precertification — The process through which certain services are pre-approved by Highmark and the member is covered for services.

Preferred Provider Organization (PPO) Program — A program based on a provider network made up of physicians, specialists, hospitals, and other health care facilities. Using this provider network helps assure that members receive maximum coverage for eligible services.

Prescription drug — A drug or compound that can only be purchased with a physician's prescription from a legally licensed pharmacist.

Pre-transplant stabilization — An inpatient stay to medically stabilize a covered person for purposes of, or preparation for, a later transplant, whether or not the transplant occurs.

Primary care physician — A physician whose practice is limited to family practice, general practice, internal medicine, or pediatrics.

Professional provider — A person, practitioner, or entity engaged in the delivery of health services and licensed or certified, when required, to perform services within the scope of such licensure or certification. Professional providers include the following:
1. Acupuncturist,
2. Audiologist;
3. Certified registered nurse*,
4. Certified registered nurse midwife,
5. Certified registered nurse practitioner (CRNP),
6. Chiropractor,
7. Clinical social worker,
8. Dentist,
9. Dietician-nutritionist,

10. Licensed practical nurse,
11. Marriage and family therapist
12. Naturopathic physician,
13. Occupational therapist,
14. Optometrist,
15. Physical therapist,
16. Physician,
17. Physician's assistant,
18. Podiatrist,
19. Professional counselor,
20. Psychologist,
21. Registered nurse,
22. Respiratory therapist,
23. Speech-language pathologist, and
24. Teacher of the hearing impaired.

*Excluded from eligibility are registered nurses employed by a health care facility or by an anesthesiology group.

Qualified Medical Child Support Order (QMCSO) — A medical child support order that:
1. Creates or recognizes the existence of a child's right to, or assigns to a child, the right to receive benefits for which a participant is eligible under the plan;
2. States the name and last known mailing address of the participant and the name and mailing address of each child (alternate recipient) covered by the order;
3. Contains a reasonable description of the type of coverage to be provided;
4. Specifies the period to which such order applies;
5. Identifies the plan to which such order applies; and
6. Does not require the plan to provide any type or form of benefit or any option not otherwise provided under the plan, except to the extent necessary to meet the requirements of a state law as described in Section 1908 of the Social Security Act, as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993.

Specialist — A physician, other than a primary care physician, who limits his or her practice to a particular branch of medicine or surgery.

Spouse — The person recognized as the employee's husband or wife under the laws of the state where the employee lives. The employee may be required to provide documentation proving a legal marital relationship.

Substance abuse — Any use of alcohol or other drugs that produces a pattern of pathological use causing impairment in social or occupational functioning or produces physiological dependency evidenced by physical tolerance or withdrawal.

Transplant — One complete series of a transplant including the pre-transplant evaluation, harvesting, stabilization, and the transplant itself. It does not include a second transplant if the first was not successful.

Urgent care facility — A freestanding facility that:
1. Is engaged primarily in providing minor emergency and episodic medical care to a member;
2. Is either accredited by the Joint Commission or licensed by the state in which it is located;
3. Includes x-ray and laboratory equipment and a life support system as part of the facilities; and
4. Is not located on or in conjunction with and is not in any way a part of a regular hospital.

You, your — The employee of a member organization who is enrolled in this plan and to whom this summary plan description is issued.

Part III, Participation — Who Can Be Covered

A. Employees

You are eligible to be covered by this plan if you are a full-time employee as determined by your member organization pursuant to the member organization's Eligibility Policy for determining full-time employee status under Internal Revenue Code §4980H (Eligibility Policy), which is attached to this summary plan description. The Eligibility Policy is incorporated herein by reference and is an integral part of this summary plan description.

Leave of Absence

You remain eligible for coverage if you are on a leave of absence approved by your member organization according to the personnel policy in effect at the time of the leave and as outlined in your member organization's Eligibility Policy.

Under any leave of absence that qualifies under the Family and Medical Leave Act of 1993 (FMLA), your coverage will be maintained under the plan on the same conditions as coverage would have been provided if you had been continuously working. This means that the same level of benefits and type of coverage available to similarly situated working employees will be available to you. You must pay the same level of premium contribution you were paying as an active employee. When you return to work you will not have to complete a new *employee eligibility waiting period*.

If you do not return to work as an active employee on the first business day that follows the last day of a leave of absence (including FMLA), coverage under the plan will terminate, unless you elect continuation of coverage (see *Part XV*).

Military Leave

Employees and their dependents who are covered under the plan on the day the employee leaves employment for military service will have plan rights as mandated by the Uniformed Services Employment and Re-employment Rights Act (USERRA). These rights include the following:

1. The right to elect up to 24 months of extended plan coverage beginning on the day the employee would otherwise lose plan coverage because of entering military service*; and
2. Immediate plan coverage with no pre-existing conditions waiting periods or exclusions applied when the employee is re-employed by the member organization upon return from military service, except for injuries or illnesses determined by the Secretary of Veterans' Affairs to have been incurred or aggravated during military service.

*If the period of military service is 30 days or less, the employee is responsible to pay the same level of premium contribution he or she was paying as an active employee. If the period of military service is 31 days or more, the employee is responsible to pay the entire cost of coverage plus a reasonable administration fee.

For more information, contact the plan representative.

B. Dependents

Your dependents may also be covered by the plan. A *dependent* includes the following:

1. Your spouse (see definition in *Part II*), provided you are not divorced or legally separated.
2. Your domestic partner as long as a domestic partnership exists with you, **but only if your member organization provides coverage for domestic partners as indicated in the *Schedule of Benefits***. To be eligible for such coverage as a domestic partner, when provided by the member organization, you and your domestic partner must:
    a. Be 18 years of age or older and not related by blood or adoption in a manner that would legally prohibit your marriage;
    b. Not be legally married to anyone else. However, if you and your domestic partner have been legally married to each other in a state or country that permits same-gender marriage, or if you have had a "full benefits civil union" in such state or country, but that marriage or civil union is not considered legal in your state of residence and/or the state of Pennsylvania, your domestic partner is eligible for coverage if all the other requirements are met.
    c. Be the sole domestic partner of each other, been living together on a continuous basis for at least six months and intend to continue living with each other in the future. Proof of cohabitation (drivers licenses, tax returns, or other documents deemed acceptable by the plan administrator) must be submitted to your member organization.
    d. Agree to be jointly responsible for the basic living expenses and welfare of the other partner; and
    e. Demonstrate financial interdependence by submission of proof of at least three of the following documents:
        1) A joint mortgage or lease;
        2) Designation of the partner as a beneficiary in the other partner's will;
        3) Durable financial and health care powers of attorney;
        4) Designation of the domestic partner as beneficiary in the employee's life insurance or retirement benefits;
        5) Joint title to an automobile, joint bank account, or joint credit account; or
        6) Such other proof as determined by the plan administrator to be sufficient to establish economic interdependence under the circumstances of the particular domestic partnership.

3. Your children under the age of 26. Your child's marital status, financial dependency, employment, residency, or student status will not be considered in determining eligibility for plan coverage to age 26.

A dependent also includes a child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (see definition in *Part II*).

For the purposes of plan coverage, the word *children* means all biological children, legally adopted children, stepchildren, foster children, and children of your domestic partner (as long as the domestic partnership exists) who meet the age requirements. The word *children* also includes a minor for whom you have accepted legal guardianship.

To be eligible for dependent coverage, proof that dependents meet the above definition may be required.

C. Dependents Who Are Disabled

If your dependent child is physically or mentally disabled and because of the disability is not able to earn a living, your child can continue to be covered as your dependent after he or she reaches age 26. In order to be eligible for plan coverage beyond age 26, your child must have become disabled before his or her 26th birthday and must continue to be entirely dependent on you for support and maintenance. You will have to give Everence a written notice from your physician that documents your child's disability within 30 days after your child's 26th birthday. Everence may ask you to provide written proof from your physician once a year certifying your child's continuing disability. You will have to pay the full cost of any required proof or certification.

The premium charged for a disabled dependent will be the same as any other adult covered person age 26 or older.

Plan coverage for a disabled dependent will continue as long as you are covered by the plan or until the earliest of the following events:
1. Your child is no longer disabled;
2. Your child is no longer entirely dependent on you for support and maintenance;
3. You do not provide proof of your child's continuing disability when Everence asks for it; or
4. Your child gets married.

D. General Provisions

If more than one family member works for a member organization, each employed family member will be covered by the plan as an employee. If both you and your spouse or domestic partner are employees, your children will be enrolled either as your dependents or the dependents of your spouse or domestic partner. In either of these cases, plan benefits will be identical to those you would receive if only one family member works for the member organization.

It is very important for your member organization to have correct, up-to-date information about you and your dependents. **Be sure to let the plan representative know when your address or any other personal information changes that may affect your coverage,** such as your marital status, the number of your dependents, their names and birth dates, etc. Changes must be reported to your member organization within 15 days following the change.

Part IV, Enrollment — When Coverage Starts

A. When Coverage Begins

Coverage for benefits begins upon meeting the eligibility and enrollment requirements outlined in *Part III* and *Part IV* of this summary plan description, and your member organization's Eligibility Policy.

B. Initial Enrollment

In order to be covered by the plan, you must enroll yourself and each of your qualified dependents (if you want dependent coverage).

Newly Hired Employees

You and your dependents can enroll in the plan by completing and returning an *Employee Enrollment for Group Health Coverage* form to the plan representative during the designated 30-day enrollment period that follows the day you are determined by your member organization to be eligible for coverage as a full-time employee, pursuant to your member organization's Eligibility Policy.

Coverage for you and your qualified dependents will be effective as outlined your member organization's Eligibility Policy as long as you enroll in the plan within the required 30-day enrollment period.

C. Enrolling New Dependents

New dependents can be enrolled in the plan during the 30-day enrollment period that immediately follows the date a dependent first becomes eligible for coverage through birth, placement for adoption, adoption, marriage, or domestic partnership. However, your dependents are not eligible to be covered under the plan until you have been determined by your member organization to be a full-time employee pursuant to your member organization's Eligibility Policy and are eligible to enroll in the plan.

Coverage for new dependents added through marriage begins on the day of marriage if they are enrolled in the plan within the 30-day enrollment period and additional premium is paid, if required.

Coverage for new dependents added through a domestic partnership begins on the day your domestic partner meets the eligibility requirements outlined in *Part III, Section B*, if they are enrolled in the plan within the 30-day enrollment period and additional premium is paid, if required.

Coverage for a newborn child begins on the day of birth if the newborn is enrolled in the plan within the 30-day enrollment period that immediately follows the date of birth and additional premium is paid, if required.

Coverage for a newly adopted child begins on the earlier of the date of adoption, placement in your home, or when the parents assume financial responsibility, if the newly-adopted child is enrolled in the plan within the 30-day enrollment period that immediately follows the date of adoption or placement for adoption and additional premium is paid, if required.

You can enroll new dependents in the plan by contacting the plan representative. If you are already enrolled in the plan when you add your first dependent, you will get a new ID card showing your dependent coverage.

D. Special Enrollment Periods

Note: The Outbreak Period is disregarded when determining the deadline for special enrollment. The Outbreak Period is the period that began March 1, 2020 and ends 60 days after the announced end of the COVID-19 national emergency.

Waiver of Coverage

If you and/or your dependents are eligible for coverage under the plan but waive coverage due to enrollment in other creditable coverage (see definition in *Part II*), you and/or your dependents may enroll in the plan later without being considered a late enrollee if employer contributions toward the other creditable coverage terminate or if eligibility for the other creditable coverage ends as a result of:

1. Termination of employment;
2. Involuntary termination of the other health plan;
3. Reduction in the number of hours of employment;
4. Legal separation, divorce, or death of a spouse or domestic partner;
5. Discontinuance of dependent coverage; or
6. Marriage or domestic partnership.

You and/or your dependents must enroll in the plan within the 30-day special enrollment period that immediately follows the day the other creditable coverage ends (or employer contributions terminate).

The effective date of coverage for an eligible individual who loses other creditable coverage will be the day after the other creditable coverage ends (or employer contributions terminate) as long as he or she enrolls in the plan within the 30-day special enrollment period.

You must inform the plan representative and complete the waiver section of the *Employee Enrollment for Group Health Coverage* form if you are waiving coverage for yourself or any dependent.

Special Enrollment Period When New Dependents Become Eligible for Coverage

An eligible employee who has not enrolled in the plan, can also enroll at the same time a new dependent becomes eligible for coverage through marriage, domestic partnership, birth, or adoption. Both must enroll within the 30-day special enrollment period that immediately follows the date the new dependent becomes eligible to enroll in the plan.

Similarly, an eligible spouse or domestic partner who has not enrolled in the plan, can enroll at the same time as a newborn or newly adopted child. Both must enroll within the 30-day special enrollment period that immediately follows the date the new dependent becomes eligible to enroll in the plan.

The effective date of coverage will be the date of marriage, domestic partnership, birth, placement for adoption, or adoption, whichever is relevant.

Special Enrollment Periods Required by the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009

If you and/or your dependents are eligible for coverage under this plan but waive coverage due to enrollment in Medicaid or a state Children's Health Insurance Program (CHIP), you and/or your dependents may enroll in the plan later without being considered a late enrollee if Medicaid or CHIP coverage ends because of loss of eligibility.

In addition, if you and/or your dependents are eligible for coverage under this plan but choose not to enroll, you and/or your dependents may enroll in the plan later without being considered a late enrollee if you and/or your dependents become eligible for a state group health plan premium assistance subsidy under Medicaid or CHIP which provides help in paying for coverage under this plan.

You and/or your dependents must enroll in the plan within the 60-day special enrollment period that immediately follows the date coverage under Medicaid or CHIP terminates or the date it is determined that you and/or your dependents are eligible for a state premium assistance subsidy, whichever applies.

The effective date of coverage will be the day after Medicaid or CHIP coverage terminates or the date you and/or your dependents become eligible for the state premium assistance subsidy, whichever is relevant.

E. Change in Employment Status

If you are already an employee of a member organization, but have not been eligible for plan coverage, you may enroll following a change in employment status that results in eligibility for plan coverage as a full-time employee, pursuant to your member organization's Eligibility Policy.

You and your dependents can enroll in the plan as outlined in your member organization's Eligibility Policy.

Coverage for you and your qualified dependents will be effective as outlined in your member organization's Eligibility Policy, as long as you enroll in the plan within the designated 30-day enrollment period.

F. Late Enrollment

Any eligible individual not enrolling in the plan within his or her respective *employee eligibility waiting period* — if required by the member organization — or enrollment or special enrollment period becomes a late enrollee. A late enrollee is only eligible to enroll in the plan during the annual open enrollment period (see *Section G* of this *Part IV*).

G. Annual Open Enrollment Period

Each year the plan offers an open enrollment period between Oct. 15 and Nov. 15. At that time, the following individuals have the opportunity to enroll in the plan:

1. Late enrollees (see *Section F* of this *Part IV*); and
2. Employees not enrolled in the plan who are determined by the member organization to be full-time employees for the new plan year, pursuant to the member organization's Eligibility Policy.

To enroll for coverage, the *Employee Enrollment for Group Health Coverage* form must be completed and returned to the plan representative prior to the last day of the open enrollment period. Coverage will be effective the following Jan. 1.

In addition, if your member organization provides two plan options, eligible employees already enrolled in the plan have the opportunity to change coverage to a different plan option during the open enrollment period. To change coverage to a different plan option, the *Employee Selection for Group Health Plan* form must be completed and returned to the plan representative before the end of the open enrollment period. The change to the new plan option will be effective the following Jan. 1.

Part V, Basis of Coverage — What Coverage Costs

The plan is currently funded by contributions made by your member organization and plan participants. Your member organization will contribute some or all of the monthly cost of coverage for you and your dependents. You must contribute any remaining cost through payroll deduction. Authorization forms are available from the plan representative. The table in *Part XXI* shows the different categories of participants and the amount of contribution required.

Plan participants who are on continuation of coverage (see *Part XV*) must pay the entire cost of their coverage plus a reasonable administrative fee.

Plan participants who are on any leave of absence that qualifies under the Family and Medical Leave Act of 1993 must pay the same level of premium contribution they were paying as an active employee.

Plan participants who extend plan coverage while on military leave (see *Part III, Section A*), must pay the same level of premium contribution they were paying as an active employee if the period of military service is 30 days or less. For periods of military service that exceed 30 days, the plan participant must pay the entire cost of coverage plus a reasonable administrative fee.

In addition to these contributions, all plan participants are responsible for paying:
1. Deductibles;
2. Coinsurance;
3. Copayments;
4. Charges resulting from the reduced plan payment level, when receiving services from an out-of-network provider;
5. Charges that exceed the allowable charge, when receiving services from an out-of-network provider; and
6. Charges for care, services, treatment, and supplies not covered by the plan.

Part VI, How Your Health Coverage Works

You need to know:
1. If you receive care from an out-of-network provider, plan payments for provider services are based on the allowable charge which is the dollar amount Highmark Blue Shield has determined is reasonable for the care, service, or treatment received by a member.

   If the provider charges are more than the allowable charge, the member will be responsible for payment of the difference. Any of these extra amounts the member is required to pay will not count toward the calendar-year deductible and coinsurance requirements or the total annual out-of-pocket maximum.

2. The plan does not pay charges for treatment of an illness or injury a member may receive or develop as the result of any work for wage or profit (including self-employment). This provision applies to any illness or injury covered by Workers' Compensation, occupational disease, or similar law. However, if specific coverage for such an illness or injury is not in effect, is not required by law, and is not available, this plan will cover eligible charges for treatment of the illness or injury.

A. Required Copayment for Office Visits

When You Go to a Network Provider

You are required to pay an office visit copayment for the office visit charge of every office visit to a professional provider who is part of the Blue Shield Preferred Provider Organization (PPO) program network (the PPO is explained in *Part VII* of this summary plan description).

The required office visit copayment is $50 for the office visit charge of a primary care physician (see definition in *Part II*) office visit and $75 for the office visit charge of a specialist (see definition in *Part II*) and urgent care facility (see definition in *Part II*) office visit. After you've paid the first $50 or $75, the plan pays 100 percent of the remaining office visit charge. Deductibles and coinsurance do not apply to the office visit charge. The office visit copayment is **not** applied toward your calendar-year deductible and coinsurance requirements but is applied toward the total annual out-of-pocket maximum.

The office visit copayment is for each covered person even if you are billed together for two visits at the same time. It applies to the office visit charge only. Charges for surgery, laboratory work, x-rays, or other services received as part

of the office visit will be paid according to the benefit provisions outlined in the *Schedule of Benefits* and *Part IX* of this summary plan description.

Exceptions

The office visit copayment does not apply when receiving benefits under the following provisions of this summary plan description:

1. Maternity services (*Part IX, Section N*);
2. Outpatient mental health care services that are not billed as an office visit charge (*Part IX, Section O*);
3. Preventive care (*Part IX, Section Q*);
4. Spinal manipulations (*Part IX, Section V*);
5. Outpatient substance abuse services that are not billed as an office visit charge (*Part IX, Section W*); and
6. Therapy and rehabilitation services (*Part IX, Section Y*).

Benefits for these services will be paid according to the benefit provisions outlined in the *Schedule of Benefits* and *Part IX* of this summary plan description. All other PPO requirements will apply.

When a Network Provider is Not Used

If you or your covered dependents receive care from a professional provider outside the PPO network (except for preventive care services), deductibles and coinsurance will apply as listed in the Out-of-Network column in the *Schedule of Benefits* rather than the office visit copayment.

If you or your covered dependents receive preventive care services from a professional provider outside the PPO network, there are no plan benefits and you will be responsible to pay the charges.

B. Required Copayment for Amwell Virtual Physician Visits

You are required to pay a $49 copayment for every virtual visit with a physician who is part of the Amwell network of physicians. After you've paid the $49 copayment for the Amwell virtual physician visit, the plan pays 100 percent of the remaining charge for the virtual visit. Deductibles and coinsurance do not apply to Amwell virtual physician visits. The $49 copayment is not applied toward your calendar-year deductible and coinsurance requirements but is applied toward the total annual out-of-pocket maximum.

The $49 copayment is for each covered person requesting an Amwell virtual physician visit, even if you request medical consultation for two family members in the same virtual physician visit.

Amwell will collect the $49 copayment from you via credit card or debit card at the time the virtual physician visit is requested.

NOTE: The plan's normal cost-sharing requirements are waived for all Amwell virtual physician visits on or after March 13, 2020 through March 31, 2021.

C. Emergency Room Copayment

You are responsible to pay the first $250 of the hospital emergency room facility charges for any emergency room visit. This amount is called an emergency room copayment and is **not** applied toward your calendar-year deductible and coinsurance requirements but is applied toward the total annual out-of-pocket maximum.

After you pay the first $250, the plan pays 100 percent of the remaining emergency room facility charges. The $250 copayment applies to the emergency room facility charges only. Emergency room services that are billed separately by emergency room providers are applied to the calendar-year deductible and coinsurance requirements.

If the covered person is admitted to the hospital, the emergency room copayment is waived, and the emergency room facility charges are subject to the calendar-year deductible and coinsurance requirements.

D. Calendar-year Deductible

The calendar-year deductible is the specific dollar amount you are required to pay for covered services each calendar year before the plan pays for all or a portion of the remaining expenses. Deductibles for individuals and families are listed in the *Schedule of Benefits*. You are responsible for paying all of the charges to which the deductible applies until you have paid the deductible requirement.

If you are the only person covered under this plan, you have met your deductible when you have paid eligible expenses equal to the individual deductible listed in the *Schedule of Benefits*.

If your family is covered under this plan, you have met your deductible when the combined eligible expenses you have paid for two or more covered persons equals the family deductible listed in the *Schedule of Benefits*. **However, no one person can contribute more than the individual deductible toward meeting the family deductible.** Once you have paid eligible expenses equal to the family deductible, the deductible will be considered satisfied for all covered family members.

Your deductible requirement remains as listed in the In-Network column in the *Schedule of Benefits* if you or your dependents receive care from network providers. If you or your dependents receive care from out-of-network providers, your deductible requirement will be the amount listed in the Out-of-Network column in the *Schedule of Benefits*.

Only expenses eligible under this plan (excluding copayments for office visits, Amwell virtual physician visits, emergency room services, and outpatient prescription drugs) can be applied toward meeting the deductible requirement.

The accumulation period for the deductible amount is a calendar year, beginning Jan. 1 and ending the following Dec. 31.

E. Calendar-year Coinsurance

The calendar-year coinsurance is the amount of eligible expenses you and this plan share after the deductible requirement has been met. The amount you and the plan share and the percentage you are required to pay are listed in the *Schedule of Benefits*. **However, no one person can contribute more than the individual coinsurance toward meeting the family coinsurance.** Once you have paid eligible expenses equal to the family coinsurance, the coinsurance requirement will be considered satisfied for all covered family members.

Only eligible expenses under this plan (excluding copayments for office visits, Amwell virtual physician visits, emergency room services, and outpatient prescription drugs) can be applied toward the coinsurance requirement. Expenses used to meet the deductible are not applied toward meeting the coinsurance requirement.

Your coinsurance requirement remains as listed in the In-Network column in the *Schedule of Benefits* if you or your dependents receive care from network providers. If you or your dependents receive care from out-of-network providers, your coinsurance requirement will be the percentage listed in the Out-of-Network column in the *Schedule of Benefits*.

At the beginning of each calendar year, after you have met the deductible requirement, you must meet a new coinsurance requirement.

F. Out-of-Pocket Maximums

Annual Out-of-Pocket Maximum for Deductible and Coinsurance

The annual out-of-pocket maximum for deductible and coinsurance is the specific dollar amount of deductible and coinsurance you must pay for eligible health care expenses each calendar year before the plan begins to pay 100 percent of additional eligible expenses subject to the deductible and coinsurance requirements for the remainder of the calendar year. The annual out-of-pocket maximum for deductible and coinsurance is listed in the *Schedule of Benefits*. The annual out-of-pocket maximum for deductible and coinsurance does not include copayments for office visits, Amwell virtual physician visits, emergency room visits, and outpatient prescription drugs; expenses for care, services, treatment, and supplies not covered by the plan; or amounts in excess of the provider's allowable charge.

Total Annual Out-of-Pocket Maximum

The total annual out-of-pocket maximum is the maximum amount of deductible, coinsurance, office visit copayments, Amwell virtual physician visit copayments, emergency room copayments, and prescription drug copayments (including the difference in price between a brand name and generic drug) you must pay for eligible health care expenses each calendar year before the plan begins to pay 100 percent of **all** additional eligible health care expenses for the remainder of the calendar year. The total annual out-of-pocket maximum is listed in the *Schedule of Benefits*. The total annual out-of-pocket maximum does not include expenses for care, services, treatment, and supplies not covered by the plan; or amounts in excess of the provider's allowable charge.

G. Maximum Benefits

The benefits provided by this plan are not subject to an overall annual or lifetime dollar maximum for any covered person.

Some benefits have calendar-year maximum limits on the number of days or number of services covered by this plan. These maximums are listed in the *Schedule of Benefits* and described in *Part IX*.

Part VII, Preferred Provider Organization Program

Your health coverage under this plan is arranged through the Highmark Blue Shield Preferred Provider Organization (PPO) Program. The PPO program allows you to get the medical care you want from the provider you select. When you or a covered dependent need medical care, you can choose between two levels of health care services – network care or out-of-network care.

Whether you or your covered dependents choose network care or out-of-network care, you are responsible to contact Healthcare Management Services (HMS) to precertify the patient's care or verify that the provider has precertified the care according to the precertification requirements outlined in *Part VIII*. The provider will not automatically do this for you.

A. Benefits When Choosing Network Care

Network care is care you receive from providers in the national BlueCard® PPO network. This network includes physicians, a wide range of specialists, community and specialty hospitals, mental health and substance abuse providers, and laboratories in your community and across the country. You and your covered dependents must select a provider in the national BlueCard® PPO network in order to receive the maximum benefits payable under this plan.

When you choose a provider in the national BlueCard® PPO network, your deductible and coinsurance remain as listed in the In-Network column in the *Schedule of Benefits*. The network provider will submit the claim for you.

You may call (800) 810-BLUE (2583) or go online at www.highmarkblueshield.com, choose the "Find a Doctor or Rx" tab and click on "Find a doctor, hospital or other medical provider" to locate the network provider nearest you or verify that your current provider is in the network.

B. Reduced Benefits When Choosing Out-of-Network Care

Out-of-network care is care you receive from providers that are not in the national BlueCard® PPO network.

If you or your covered dependents receive out-of-network care for services other than preventive care services or emergency services provided by a hospital, emergency room, or ambulance, even if you are referred to an out-of-network provider by a network provider, benefits will be reduced. The deductible and coinsurance requirements will be increased to the amounts listed in the Out-of-Network column in the *Schedule of Benefits*. You will also be responsible to pay all charges that exceed the allowable charge for eligible services received.

If you or your covered dependents receive preventive care services from a professional provider outside the PPO network, there are no plan benefits and you will be responsible to pay the charges.

If you or your dependents receive out-of-network care, you are still responsible to follow all precertification requirements outlined in *Part VIII*. You are also responsible to make sure a claim form is completed and submitted to the address on your ID card.

C. Out-of-Area Care

The PPO program also covers care when you or your covered dependents are traveling or otherwise away from home. Services received from providers across the country who are part of the national BlueCard® PPO network will be paid at the in-network benefit level. If you receive services from an out-of-network provider, benefits will be reduced as outlined in *Section B* above.

You or your dependents do not need to receive care through a network provider in the event of an emergency or if urgent injury or illness occurs. In this case, you should seek treatment from the nearest hospital or emergency room.

If the illness or injury is not a true emergency and you receive care from an out-of-network provider, benefits will be reduced as outlined in *Section B* above.

If the illness or injury is a true emergency, eligible services received will be paid as in-network benefits, regardless of whether the provider is a network provider. If the treatment results in an inpatient admission, you are responsible to contact Healthcare Management Services (HMS) at the precertification number on your ID card to precertify the patient's care according to the precertification requirements outlined in *Part VIII*. This must be done within 48 hours after the emergency admission.

If emergency treatment is being provided by a hospital or other facility provider outside the national BlueCard® PPO network, the patient may be required — when medically appropriate — to transfer to a hospital or facility provider that is part of the PPO network.

If you or your dependents do not transfer to a provider that is part of the PPO network as requested when medically appropriate, benefits will be reduced as outlined in *Section B* above.

D. Blue Cross Blue Shield Global Core Program

When you travel abroad, your coverage travels with you. The Blue Shield symbol on your ID card is recognized around the world. The PPO program provides all of the services of the Blue Cross Blue Shield Global Core Program. These services include access to a worldwide network of health care providers. Medical assistance services are also provided. You can access these services by calling (800) 810-BLUE (2583) or logging onto www.bcbsglobalcore.com.

The Blue Cross Blue Shield Global Core Program provides the following services to members:
1. Making referrals and appointments for you with nearby physicians and hospitals;
2. Verbal translation from a multilingual service representative;
3. Providing assistance if special help is needed;
4. Making arrangements for medical evacuation services; and
5. Processing inpatient hospitalization claims.

For outpatient or professional services received abroad, you should pay the provider, then complete a Blue Cross Blue Shield Global Core International claim form and send it with the provider's itemized bill(s) to the Service Center address on the claim form to initiate claims processing. The claim form is available from Highmark, the Service Center, or online at www.bcbsglobalcore.com. For assistance with submission of claims, call the Service Center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week.

E. Outpatient Prescription Drugs

Pharmacies are not part of the national BlueCard® PPO network. See the *Outpatient Prescription Drug Rider* attached to this summary plan description for guidelines when purchasing outpatient prescription drugs.

Part VIII, Precertification and Claims Management

In order for benefits to be paid under this plan, the services, treatment, or supplies must be considered medically necessary and appropriate. Healthcare Management Services (HMS), a division of Highmark Blue Shield, is responsible for determining that care is medically necessary and provided in the appropriate setting.

This plan requires that you notify HMS in advance if you or your covered dependents need inpatient care. You can contact HMS at the toll-free Member Service number on the back of your ID card.

Through this process HMS can help reduce costs without sacrificing the quality of care. All rules and guidelines for this are given below. Please read all the instructions carefully.

Whether you are admitted to a network facility or an out-of-network facility, you are responsible to contact HMS to precertify the patient's care or verify that the provider has precertified the care. The provider will not automatically do this for you.

A. Initial Precertification of Hospitalization and Other Inpatient Treatment

You or your representative must notify HMS **7-10 days** prior to any non-emergency planned admission to an inpatient facility, including a:

1. Hospital (including admission for treatment of mental illness or substance abuse);
2. Skilled nursing facility;
3. Rehabilitative center; or
4. Other inpatient facility.

You need to notify HMS **within 48 hours** or as soon as reasonably possible following an emergency admission to any inpatient facility.

You do not need to notify HMS prior to an inpatient admission for delivery of a child if the inpatient stay is no longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery. If the inpatient admission extends beyond 48 hours for a vaginal delivery or 96 hours for a cesarean delivery, you must notify HMS in advance of the extended stay.

HMS must be notified of any inpatient admission required for pre- or postnatal care not directly related to the delivery of a child.

An HMS nurse will complete a review of the request for inpatient admission to ensure it is:

1. Appropriate for the symptoms and diagnosis or treatment of the patient's condition, illness, disease, or injury;
2. Provided for the patient's diagnosis or the direct care and treatment of the patient's condition, illness, disease, or injury;
3. Not primarily for the convenience of the patient or the health care provider;
4. In accordance with standards of good medical practice; and
5. The most appropriate supply or level of service that can safely be provided to the patient. When applied to hospitalization, this means the patient requires acute care as an inpatient due to the nature of services required for the patient's condition and the patient cannot receive safe or adequate care as an outpatient.

B. HMS Care/Utilization Review Process

In order to assess that care is provided in the appropriate setting, HMS administers a care utilization review program comprised of prospective, concurrent, and/or retrospective reviews. In addition, HMS assists hospitals with discharge planning. These review procedures are as follows:

Prospective Review

Prospective review, also known as precertification or pre-service review, begins upon receipt of treatment information. After receiving the request for inpatient admission, HMS:

1. Reviews available information regarding the patient's eligibility for coverage and/or availability of benefits;
2. Reviews the information provided, including patient demographics, diagnosis, and plan of treatment;
3. Assesses whether the inpatient stay is medically necessary and appropriate for the symptoms and diagnosis or treatment of the patient's condition, illness, disease, or injury;
4. Authorizes care or refers the request to a physician advisor for determination; and
5. Assigns an appropriate length of stay for the inpatient admission.

Concurrent Review

Concurrent review may occur during the course of ongoing inpatient treatment to assess the medical necessity and appropriateness of the length of stay and level of care. HMS will:

1. Review the patient's progress and ongoing treatment plan with the facility staff; and
2. Decide, when necessary, to either:
   a. Extend the patient's care;
   b. Offer an alternative level of care; or
   c. Refer to the physician advisor for a decision.

This plan will not pay for an inpatient stay that extends beyond the number of days HMS has initially authorized — unless the attending physician requests extension of an authorized stay and HMS determines the extended stay is medically necessary and appropriate.

Discharge Planning

Discharge planning is a process that begins prior to the patient's scheduled inpatient admission. HMS will work with the patient, the patient's family, the attending physician, and hospital staff to help plan and coordinate the patient's discharge to ensure that the patient receives safe and uninterrupted care when needed at the time of discharge.

In planning for discharge, HMS assesses the patient's:

1. Level of function pre- and post-admission;
2. Ability to perform self-care;
3. Primary caregiver and support system;
4. Living arrangements pre- and post-admission;
5. Special equipment, medication, dietary, and safety needs;
6. Obstacles to care;
7. Need for referral to case management or condition management; and
8. Psychological needs.

Retrospective Review

Retrospective review may occur when a service or procedure has been rendered without the required precertification. HMS will review the service or procedure to determine if it was medically necessary and appropriate. If it was determined not to be medically necessary and appropriate, the charges will not be covered by the plan and you will be responsible to pay the charges.

Case Management Services

If you experience a serious injury or illness, or need assistance in coordinating your care needs, the Case Management program may be able to provide assistance.

If you are accepted into the program and give your permission, the Case Management program will:

1. Work collaboratively with you, your family or significant others, and your providers to coordinate and implement a plan of care that meets your holistic needs;
2. Help identify community-based support and educational services to assist with your ongoing health care needs; and
3. Assist in the coordination of benefits and alternative resources.

C. Initial Precertification and Other Pre-Service Claims Decisions

Pre-service Claims

A precertification or other pre-service claim (see definition in *Part II*) will be decided by HMS, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date Highmark receives the claim. However, this 15-day period of time may be extended once for an additional 15 days if Highmark determines additional time is necessary due to circumstances beyond its control. In this case, Highmark will notify you of the extension in writing prior to the expiration of the initial 15-day pre-service claim determination period. The notification will include the reason for the delay and the date a determination is expected.

If an extension of time is necessary because additional information is needed from you to decide the precertification or other pre-service claim, the extension notice will describe the specific information you need to submit to the plan. In this event, you will be given at least 45 days from the day you receive the extension notice to provide the information before a decision is made on your precertification or other pre-service claim. When HMS receives the information, HMS will make a determination of your claim within 15 days following receipt of the information and will notify you in writing whether or not your initial precertification or other pre-service claim is approved.

Urgent Care Claims

A precertification or other pre-service claim that is an urgent care claim (see definition in *Part II*) will be decided by HMS on an expedited basis, but no later than 72 hours following receipt of the claim. If HMS is unable to make a determination because of insufficient or incomplete information, HMS will notify you within 24 hours of receipt of the claim, specifying what information is needed to complete the claim. You will be given at least 48 hours to provide the information to HMS. When the information is received, HMS will make a determination of your urgent care claim as soon as possible, but no later than 48 hours after the earlier of HMS's receipt of the information or the end of the period given to you to provide the additional information. You will be notified in writing whether or not your initial urgent care claim is approved.

In addition, the 72-hour time frame may be shortened in those cases where your urgent care claim request seeks extension of a previously approved course of treatment and the request is made at least 24 hours prior to the end of the previously approved course of treatment. In this case, HMS will make a determination of your urgent care claim request to extend the course of treatment no later than 24 hours after HMS receives your request.

D. Failure to Follow Required Precertification Procedures

If you or your authorized representative fail to follow the plan's precertification procedures when making an urgent care, precertification, or other pre-service claim, HMS will notify you of the failure and the proper procedures to be followed. Notice will be provided to you as soon as possible following the failure, but no later than five days for a

precertification or other pre-service claim or 24 hours for an urgent care claim. Notification may be provided to you orally unless you or your representative request a written notice. This only applies when you fail to follow plan procedures for a precertification or other pre-service claim that:

1. Is received by the department of Highmark customarily responsible for handling benefit matters (HMS); and
2. Names a specific claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which precertification is requested.

E. If an Initial Precertification or Other Pre-Service Claim is Denied

If your request for precertification or approval of a pre-service claim is denied by HMS, the written notice informing you of the denial will include information about the adverse benefit determination and your right to file an appeal, as outlined in *Part XIII.*

Everence Insurance Company (Everence) will notify you of any initial preauthorization determination or concurrent care review that results in an adverse benefit determination, as outlined in *Part XIII, Section A,* when a request for preauthorization of specialty pharmaceuticals, compound prescription drugs costing $300 or more, or drugs costing $5,000 or more is denied.

The plan will not cover any charges in connection with a precertification, preauthorization, or other pre-service claim that is denied.

Part IX, Covered Services

This plan covers the allowable charges (see definition in *Part II*) for services or supplies that are medically necessary and appropriate for the treatment of an injury or illness, provided these charges are not listed under *Part X*.

All covered charges are subject to the deductible, coinsurance, and copayment listed in the *Schedule of Benefits*. In addition, you are required to precertify an inpatient admission according to the precertification procedures outlined in *Part VIII*.

A. Acupuncture Services

The plan covers the following acupuncture services, up to a combined limit of 36 visits* per calendar year:

1. Administration of acupuncture as anesthesia when ordered by the attending professional provider and rendered by a professional provider other than the surgeon or the assistant at surgery; and
2. Therapy services performed either on an inpatient or outpatient basis, which are medically necessary and appropriate, ordered by a physician, and performed by a professional provider.

*The combined limit of 36 visits per calendar year applies to acupuncture, physical medicine, speech therapy, and occupational therapy visits (see *Section Y* of this *Part IX*).

B. Ambulance Services

The plan covers local transportation by a specially designed and equipped vehicle used only to transport the sick and injured:

1. From the patient's home to a hospital;
2. From the scene of an accident or medical emergency to a hospital;
3. Between hospitals; or
4. Between a hospital and a skilled nursing facility.

Local transportation is covered to the closest hospital or facility that can provide services appropriate to the patient's condition.

The plan also covers local transportation by a specially designed and equipped vehicle used to transport the sick and injured:
1. From a hospital to the patient's home; and
2. From a skilled nursing facility to the patient's home.

C. Amwell Virtual Physician Visits

This plan covers Amwell virtual medical consultations provided by physicians who are part of the Amwell physician network. Amwell allows members to access Amwell physicians via telephone, computer, or mobile applications (iPhone, iPad, etc.) for most routine, non-emergency medical conditions (such as cold and flu symptoms, allergies, sinus problems, yeast or urinary tract infections, etc.). Amwell virtual physician visits are available 24 hours a day, seven days a week from any location within the United States. Through an Amwell virtual physician visit, the physician can diagnose and treat your non-emergency illness and prescribe medications when appropriate (some states may require a video visit for an Amwell physician to prescribe medications).

To access Amwell, visit the Amwell website at www.amwell.com and follow the instructions to create an account and download the mobile app. After an account is set up, a virtual physician visit with an Amwell physician may be requested by logging onto your online account through the Amwell website or the Amwell mobile app. You may also call 1-844-SEE-DOCS (1-844-733-3627) to request a virtual physician visit with an Amwell physician.

Amwell virtual physician visits are subject to the copayment outlined in *Part VI, Section B,* which is collected from you via credit card or debit card at the time the virtual physician visit is requested.

NOTE: The plan's normal cost-sharing requirements are waived for all Amwell virtual physician visits on or after March 13, 2020 through March 31, 2021.

D. Clinical Trials

The plan covers routine patient costs for items and services furnished to a qualified individual in connection with an approved clinical trial.

For the purposes of this provision, the following definitions apply:

Approved clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is:
1. Conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is federally funded through a variety of entities or departments of the federal government;
2. Conducted in connection with an investigational new drug application reviewed by the U.S. Food and Drug Administration; or
3. Exempt from investigational new drug application requirements.

Life-threatening condition is a disease or condition likely to result in death unless the course of the disease or condition is altered.

Qualified individual is a group health plan participant who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening disease or condition and either:
1. The referring health care professional is a participating provider and has concluded that the participant's participation in the clinical trial would be appropriate; or
2. The participant provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

Routine patient costs include items and services covered by the plan for a plan participant not enrolled in a clinical trial. Such items and services do not include the following:
1. The investigational item, device, or service itself;
2. Items and services not included in the direct clinical management of the patient, but provided in connection with data collection and analysis; or
3. A service clearly not consistent with widely accepted established standards of care for the particular diagnosis.

E. COVID-19 Testing and Related Services

Effective Feb. 4, 2020 and for the duration of the public health emergency related to COVID-19, the plan covers diagnostic testing for COVID-19 and related items and services without applying the plan's normal cost sharing requirements. Related items and services are those provided during a health care provider office visit (including telehealth visits), urgent care center visit, or emergency room visit that results in an order for or administration of COVID-19 testing. Related items and services are covered without cost sharing only to the extent the items and services relate to the furnishing or administration of COVID-19 testing or the evaluation of the individual's need for COVID-19 testing. The plan's normal cost sharing requirements will apply to unrelated items and services.

F. Dental Services

The plan covers charges for the dental services listed below which are rendered by a physician or dentist and are medically necessary and appropriate:

1. Dental services required as a result of accidental injury to the jaw, sound natural teeth, mouth, or face. Injury caused by chewing or biting is not considered accidental injury.
2. Oral surgical procedures as follows:
   a. Extraction of partially or completely unerupted bony, impacted teeth;
   b. Extraction of teeth in preparation for radiation therapy;
   c. Mandibular staple implant when not done to prepare the mouth for dentures;
   d. Lingual frenectomy, frenotomy, or frenoplasty (to correct tongue-tie);
   e. Facility provider and anesthesia services rendered in conjunction with non-covered dental procedures when determined by Highmark to be medically necessary and appropriate due to the patient's age and/or medical condition;
   f. Treatment of accidental injury to the jaw or structures contiguous to the jaw;
   g. Correction of a non-dental physiological condition which has resulted in a severe functional impairment;
   h. Treatment of tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof, and floor of the mouth; and
   i. Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.
3. Administration of anesthesia for outpatient oral surgical procedures when ordered and administered by the attending professional provider.

G. Diabetes Treatment

The plan covers the following when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items:

1. Equipment and supplies, such as blood glucose monitors, monitor supplies, and insulin infusion devices*; and
2. Diabetes education program (see definition in *Part II*) when the attending physician certifies that the patient requires diabetes education as an outpatient and services are provided through a diabetes education program. The following services are covered when provided under a diabetes education program:
   a. Medically necessary and appropriate visits upon the initial diagnosis of diabetes; and
   b. Subsequent visits when the attending physician:
      1) Identifies or diagnoses a significant change in the patient's symptoms or condition that requires changes in self-management; or
      2) Identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to the treatment and/or management of diabetes.

   Outpatient diabetes education services will be covered subject to Highmark Blue Shield's criteria which is based on certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA).

*Blood glucose monitors, monitor supplies, and insulin infusion devices are also covered under the outpatient prescription drug provision outlined in the *Outpatient Prescription Drug Rider* attached to this summary plan description.

H. Diagnostic Services

The plan covers the following diagnostic services when ordered by a professional provider:
1. Computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), and positron emission tomography/computed tomography (PET/CT scan);
2. Diagnostic x-rays, ultrasound, and mammography for medical purposes;
3. Diagnostic pathology consisting of laboratory and pathology tests;
4. Diagnostic medical services consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing; and
5. Allergy testing consisting of percutaneous, intracutaneous, and patch tests.

I. Enteral Formulae

The plan covers the following enteral formulae (see definition in *Part II*) when administered on an outpatient basis:
1. Amino acid-based elemental medical formulae ordered by a physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders, and short bowel syndrome;
2. Nutritional supplements administered under the direction of a physician for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria;
3. Enteral formulae prescribed by a physician, considered to be the sole source of nutrition and provided:
   a. Through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or
   b. Orally and identified as one of the following types of defined formulae with: hydrolyzed (pre-digested) protein or amino acids, specialized content for special metabolic needs, modular components, or standardized nutrients.

   Once it is determined that the above criteria have been met, coverage for enteral formulae will continue as long as it represents at least 50 percent of the individual's daily caloric requirement.

Coverage for enteral formulae **does not** include the following:
1. Blenderized food, baby food, or regular shelf food;
2. Milk or soy-based infant formulae with intact proteins;
3. Any formulae, when used for the convenience of you or your family members;
4. Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation, or maintenance;
5. Semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; or
6. Normal food products used in the dietary management of the disorders outlined above.

J. Home Health Care/Hospice Care Services

The plan covers the following services provided by a home health care agency, hospice care agency, or a hospital program for home health care and/or hospice care:
1. Skilled nursing services of a registered nurse or licensed practical nurse*, excluding private duty nursing services;
2. Physical medicine, occupational therapy, and speech therapy, subject to the limitations outlined in *Part IX, Section Y*;
3. Medical and surgical supplies provided by the home health care agency or hospital program for home health care or hospice care;
4. Oxygen and its administration;
5. Medical social service consultations;
6. Health aide services when the patient is also receiving covered nursing or therapy and rehabilitation services; and
7. Family counseling related to the patient's terminal condition.

*The services of a licensed practical nurse will be made available only when the services of a registered nurse are not available and only when medically necessary and appropriate. Services of a licensed practical nurse are only reimbursable through a facility provider.

Exclusions

The plan will not provide home health care/hospice benefits for the following:
1. Dietitian services;
2. Homemaker services;

3. Maintenance therapy;
4. Dialysis treatment;
5. Custodial care;
6. Private duty nursing services; and
7. Food or home-delivered meals.

K. Home Infusion and Suite Infusion Therapy Services

The plan covers services provided by a home infusion therapy and/or suite infusion therapy provider at an infusion suite or in a home setting. Covered charges include pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies, and nursing services associated with infusion therapy. Specific adjunct non-intravenous therapies are covered when administered only in conjunction with infusion therapy.

L. Hospital Services

Note: the plan covers in-network, inpatient hospital care for COVID-19 treatment without applying the plan's normal cost-sharing requirements for inpatient services incurred on or after February 1, 2020 through March 31, 2021.

The plan covers the following inpatient and outpatient services received in a hospital or other facility provider.

Covered Outpatient Hospital Services

1. Operating, recovery, treatment, and emergency rooms and equipment;
2. Outpatient emergency treatment of an accidental injury or a medical condition manifesting itself by acute symptoms that require immediate attention;
3. Whole blood, administration of blood, blood processing, and blood derivatives;
4. Medical and surgical supplies such as casts, dressings, splints, etc.;
5. X-rays, laboratory tests, and other diagnostic services prescribed by the attending physician, including outpatient pre-admission testing prior to a scheduled admission to the hospital as an inpatient;
6. Hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies, and services rendered by an employee of the hospital or facility provider. Administration of anesthesia ordered by the attending physician and rendered by a professional provider other than the surgeon or assistant surgeon;
7. Surgical pathology; and
8. Outpatient therapy and rehabilitation services. Charges for occupational therapy, speech therapy, and physical medicine are subject to the limitations outlined in *Part IX, Section Y.*

Covered Inpatient Hospital Services

1. Room and board while confined in a semiprivate room of a hospital.
2. Room and board while confined in a special care unit where intensive care to the critically ill is provided.
3. Room and board while confined in a private room of a hospital. Private room allowance is the hospital's most common daily **semiprivate** room charge for each day of confinement in a private room.
4. Other services and supplies prescribed by the attending physician, such as:
    a. General nursing services;
    b. Operating, delivery, treatment, and recovery rooms and equipment;
    c. Anesthesia, anesthesia supplies, and services rendered in a hospital or facility provider by an employee of the hospital or facility provider. Administration of anesthesia ordered by the attending physician and rendered by a professional provider other than the surgeon or assistant surgeon;
    d. Special diets;
    e. X-rays, laboratory tests, and other diagnostic services;
    f. Drugs and medicines;
    g. Oxygen;
    h. Whole blood, administration of blood, blood processing, and blood derivatives;
    i. Medical and surgical supplies such as casts, dressings, splints, etc.; and
    j. Therapy and rehabilitation services.

When a member is admitted to a hospital, you are responsible to contact HMS to precertify the patient's care according to the precertification requirements outlined in *Part VIII*. The hospital or attending physician will not automatically do this for you.

M. Infertility Services

The plan covers charges relating to infertility (see definition in *Part II*), including:

1. Diagnostic testing, including but not limited to, sperm count, endometrial biopsy, hysterosalpingography, and diagnostic laparoscopy;
2. Treatment of the underlying cause of male sterility or female infertility; and
3. Treatment leading to or in connection with assisted fertilization, such as, but not limited to:
   a. Fertility drugs (covered according to the terms of the *Outpatient Prescription Drug Rider*),
   b. Artificial insemination,
   c. In-vitro fertilization (IVF),
   d. Gamete intrafallopian transfer (GIFT),
   e. Zygote intrafallopian transfer (ZIFT),
   f. Embryo transplant,
   g. Tubal embryo transfer (TET),
   h. Peritoneal ovum sperm transfer zona drilling, and
   i. Sperm microinjection.

   Assisted fertilization services are covered by the plan up to a lifetime maximum of $10,000 for medical services and $3,000 for prescription drugs for each covered person.

   The plan does not cover:
   a. Medical services rendered to a surrogate during pregnancy and childbirth;
   b. Costs associated with cryo-preservation and storage of sperm, eggs, and embryos;
   c. Non-medical costs of an egg or sperm donor; and
   d. Infertility treatments deemed experimental in nature.

N. Maternity Services

The plan covers maternity charges for any member in connection with a pregnancy or complications of pregnancy (see definition in *Part II*). All eligible maternity charges, including prenatal visits, medically necessary and appropriate sonograms, delivery, postpartum care, and routine newborn care in the hospital, that are incurred on or after the effective date of coverage will be covered by the plan regardless of when the pregnancy began.

Coverage for the mother and newborn includes 48 hours of inpatient care following normal vaginal delivery and 96 hours of inpatient care following a cesarean section, as provided in the Newborns' and Mothers' Health Protection Act of 1996 which applies to this plan. The inpatient stay can be shorter if the physician, in consultation with the mother, determines that medical criteria for an earlier discharge is met.

If medical criteria for safe discharge is met and discharge occurs prior to 48 hours following normal vaginal delivery or 96 hours following a cesarean section, the plan will pay for one home health care visit within 48 hours after discharge by a licensed network health care provider whose scope of practice includes postpartum care. The home health care visit includes parent education, assistance, and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. At the mother's request, the visit may occur at the office of the licensed network health care provider.

Physician, hospital, and testing charges are covered as described in those sections of this summary plan description. Remember to enroll the new baby in the plan within the 30-day enrollment period that immediately follows the date of birth. To do this, contact the plan representative.

If you do not enroll the newborn as required by this plan, he or she will be considered a late enrollee and will only be able to enroll in the plan during the annual open enrollment period (see *Part IV, Section G*).

If you are pregnant, now is the time to enroll in the Baby BluePrints® Maternity Education and Support Program offered by Highmark. See Part XIX, Section E, for more information.

O. Mental Health Care Services

The plan covers inpatient and outpatient mental health care services provided by a professional provider for treatment of mental illness if the member is confined in a hospital, residential treatment facility, or other facility provider specializing in such treatment. The plan covers the following services:

1. Inpatient hospital services provided by a hospital, residential treatment facility, or other facility provider;
2. Partial hospitalization received through a partial hospitalization program;

3. Individual psychotherapy;
4. Group psychotherapy;
5. Psychological testing;
6. Counseling with family members to assist in the patient's diagnosis and treatment;
7. Medication checks;
8. Biofeedback;
9. Medical hypnotherapy; and
10. Electroshock treatment or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional provider.

Inpatient and outpatient mental health care services are covered as any other illness.

When a member is admitted to a hospital, residential treatment facility, or other facility provider for inpatient treatment of mental illness, you are responsible to contact HMS to precertify the patient's care according to the precertification requirements outlined in *Part VIII*. The hospital, residential treatment facility, other facility provider, or attending physician will not automatically do this for you.

P. Orthotic Devices

The plan covers purchase, fitting, necessary adjustment, repairs, and replacement of rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part. Orthotic devices covered by the plan include, but are not limited to casts, splints, trusses, braces, and orthopedic shoes when part of a leg brace. The plan does not cover foot orthotic devices when not part of a leg brace.

Q. Preventive Care Services

The schedule of covered preventive care services is outlined in Highmark's *Preventive Schedule* and *Women's Health Preventive Schedule* and is based on the requirements of the Patient Protection and Affordable Care Act of 2010 (ACA), recommendations of organizations such as Bright Futures/American Academy of Pediatrics, the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the Health Resources and Services Administration (HRSA). The schedules are updated periodically, based on changes in clinical practice guidelines. For a current schedule of covered services, log onto the Highmark member website, www.highmarkblueshield.com or call Member Service at the phone number listed on the back of your ID card. Covered preventive care services are not subject to the deductible, coinsurance, or copayment requirements of the plan.

You must receive eligible preventive care services from a network provider for the charges to be covered by the plan. **If preventive care services are received from an out-of-network provider, there are no plan benefits and you will be responsible to pay the charges.**

Adult Preventive Care Services (for adults ages 19+)

Adult preventive care services covered by the plan include, but are not limited to the following:

1. Routine physical examinations, including a complete medical history, height and weight measurement, only when performed by a network provider; and selected routine diagnostic screenings as listed in Highmark's *Preventive Schedule*, including a complete blood count (CBC) and urinalysis.
2. One routine gynecological examination per calendar year, including a pelvic and clinical breast examination, for female members, regardless of age.
3. One routine pap smear per calendar year for female members, regardless of age.
4. Routine mammographic screenings (only if performed by a properly certified mammography service provider) as follows:
   a. One routine mammographic screening per calendar year for female members age 40 and over; and
   b. Routine mammographic screening as based on a physician's recommendation for all female members regardless of age.
5. Well-woman visits to obtain recommended preventive services, as listed in Highmark's *Preventive Schedule* and *Women's Health Preventive Schedule*.
6. Routine prostate cancer screening, including an annual prostate specific antigen test and/or digital rectal exam.
7. Immunizations and therapeutic injections required for the diagnosis, prevention, and treatment of an injury or illness, as listed in Highmark's *Preventive Schedule*. The plan does not cover immunizations required for foreign travel or employment.
8. Services for prevention of obesity, heart disease, and diabetes for adults with a body mass index (BMI) of 25+, as listed in Highmark's *Preventive Schedule*.

9. Diabetes prevention program (see definition in *Part II*) delivered by a diabetes prevention provider (see definition in *Part II*) for adults meeting certain medical criteria for having a high risk of developing type 2 diabetes, as listed in Highmark's *Preventive Schedule.*
10. Tobacco cessation counseling and medication.
11. Preventive care screenings and procedures for pregnant women, as listed in Highmark's *Preventive Schedule* and *Women's Health Preventive Schedule*.
12. Breast-feeding (lactation) counseling and support, including costs of breastfeeding equipment.
13. As prescribed, risk reducing breast cancer medications (Tamoxifen or Raloxifene) for women ages 35 and older without a cancer diagnosis who are determined by their physician to be at increased risk for breast cancer and at low risk for adverse medication effects.
14. As prescribed, all FDA-approved contraceptive methods (including sterilization, oral contraceptive drugs, transdermal contraceptive patches, contraceptive injectables, contraceptive implants, and contraceptive devices) for all women with reproductive capacity.
15. Preventive drug measures when prescribed by a physician, including select generic statin drugs for prevention of cardiovascular disease, and HIV preexposure prophylaxis (PrEP), as listed in Highmark's *Preventive Schedule.*

Pediatric Preventive Care Services (for children under age 19)

Pediatric preventive care services covered by the plan include, but are not limited to the following:

1. Routine physical examinations, including a complete medical history, height and weight measurement; and selected routine diagnostic screenings as listed in Highmark's *Preventive Schedule*.
2. Pediatric immunizations, including immunizing agents, when performed and billed by a hospital, facility provider, physician, or other professional provider. The schedule of immunizations will conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and the U.S. Dept. of Health and Human Services. The plan does not cover immunizations required for foreign travel or employment.
3. Oral fluoride for children ages 6 months to 16 years whose primary water source is deficient in fluoride.
4. Services for prevention of obesity, and heart disease for children with a body mass index in the 85th to 98th percentile, as listed in Highmark's *Preventive Schedule*.

R. Private Duty Nursing Services

The plan covers private duty nursing ordered by a physician that is provided by a registered nurse or licensed practical nurse who is not an immediate family member and who does not normally live with the member. The plan covers private duty nursing for a member:

1. Who is an inpatient in a hospital or other facility provider only when Highmark determines that the nursing services required are of a nature or degree of complexity or quantity that cannot be provided by the regular nursing staff; and
2. At home only when Highmark determines that the nursing services require the skills of a registered nurse or licensed practical nurse.

S. Professional Provider Services

The plan covers the following services received from a professional provider (see definition in *Part II*):

1. Medical care to any member while a hospital inpatient. The plan will cover:
   a. Care for a medical condition by a professional provider who is not your surgeon while you are in the hospital for surgery;
   b. Care by two or more professional providers during the same hospital stay when the nature or severity of the patient's condition requires the skills of separate physicians;
   c. Consultation by another professional provider qualified by special training or experience when requested by the attending professional provider to help diagnose or treat the patient's condition, not including staff consultations which are required by the facility provider's rules and regulations;
   d. Inpatient medical care visits;
   e. Intensive medical care and treatment when the patient's condition requires it for a prolonged period of time; and
   f. Routine newborn care to examine the newborn while the mother is an inpatient.
2. Outpatient medical care visits, virtual visits*, and consultations to examine, diagnose, and treat an illness or injury.

   ***The plan's normal cost-sharing requirements are waived for all virtual physician visits with non-Amwell network physicians on or after March 13, 2020 through March 31, 2021.**

T. Prosthetic Appliances

The plan covers the following:

1. Purchase, fitting, necessary adjustments, repairs, and replacement of prosthetic devices and supplies that replace all or part of:
   a. A missing body organ and its adjoining tissues; or
   b. The function of a permanently inoperative or malfunctioning body organ.
2. Initial and subsequent prosthetic devices to replace a removed breast or a portion thereof.

The plan covers the initial set of cataract lenses needed after cataract surgery but does not cover dental appliances or the replacement of cataract lenses.

U. Skilled Nursing Facility Services

The plan covers charges for room, board, and general nursing care while confined in a skilled nursing facility. Skilled nursing facility services must be ordered by a physician and determined to be medically necessary and appropriate.

Skilled nursing facility services will be covered by the plan up to 100 days per calendar year.

The plan does not cover charges for skilled nursing facility services:

1. After the patient has reached the maximum level of recovery possible for his or her specific condition and no longer requires definitive treatment other than routine supportive care;
2. When confinement in a skilled nursing facility is intended solely to assist the patient with activities of daily living or to provide an institutional environment for the patient's convenience; or
3. For treatment of mental illness or substance abuse.

When a member is admitted to a skilled nursing facility, you are responsible to contact HMS to precertify the patient's care according to the precertification requirements outlined in *Part VIII*. The skilled nursing facility or attending physician will not automatically do this for you.

V. Spinal Manipulations

The plan covers spinal manipulations for the detection and correction, by manual or mechanical means, of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Spinal manipulations and other treatment received in conjunction with spinal manipulations are covered by the plan up to 12 visits per calendar year.

W. Substance Abuse Services

Inpatient Substance Abuse Services

The plan covers detoxification and non-hospital residential and rehabilitation therapy services received in a hospital, substance abuse treatment facility, non-hospital residential treatment facility, other facility provider, or from a professional provider for treatment of substance abuse.

Inpatient substance abuse services are covered as any other illness.

When a member is admitted to a hospital, substance abuse treatment facility, residential treatment facility, or other facility provider for inpatient treatment of substance abuse, you are responsible to contact HMS to precertify the patient's care according to the precertification requirements outlined in *Part VIII*. The hospital, substance abuse treatment facility, residential treatment facility, other facility provider, or attending physician will not automatically do this for you.

Outpatient Substance Abuse Services

The plan covers the following outpatient rehabilitation services for treatment of substance abuse provided by an outpatient hospital or substance abuse treatment facility:

1. Individual counseling;
2. Group counseling;
3. Partial hospitalization;
4. Psychotherapy;
5. Psychological testing; and

6. Family counseling.

Outpatient substance abuse services are covered as any other illness.

X. Surgical Services

A covered surgery is one that is medically necessary and appropriate and is performed by a professional provider in connection with the treatment of an illness or injury which is not work related. The plan covers charges for the following:

1. Surgery performed by a professional provider, including pre- and post-surgery visits;
2. Assistant surgeon fees, only if medically necessary and appropriate;
3. Facility charges for the operating and recovery rooms and miscellaneous medical supplies, such as dressings and bandages;
4. Anesthesia and anesthesia supplies;
5. Administration of anesthesia if ordered by the attending professional provider and administered by a professional provider other than the surgeon or assistant surgeon; and
6. Second surgical opinion provided by a consulting physician and related diagnostic services to confirm the need for recommended elective surgery. Elective surgery is covered surgery that may be deferred and is not an emergency. Please keep in mind that:
   a. Use of a second surgical opinion is your option;
   b. The second surgical opinion must be provided by someone other than the physician who recommended the elective surgery;
   c. A third surgical opinion and directly related diagnostic services are covered if the first and second surgical opinions conflict; and
   d. If the consulting opinion is against elective surgery and you decide to have the elective surgery, the surgery will be covered by the plan. In this case, the patient will be eligible for a maximum of two such consulting opinions involving the elective surgical procedure in question but limited to one consultation per consultant.

When more than one surgical procedure is performed at the same time by the same professional provider, the total benefits payable by the plan will be the allowable charge for the highest paying procedure and no payment will be made for additional surgical procedures, unless approved by the plan.

Mastectomy and Reconstructive Surgery Following a Mastectomy

The plan will cover a mastectomy and breast reconstruction in connection with a mastectomy. Eligible charges include:

1. A mastectomy performed on an inpatient or outpatient basis. If the mastectomy is performed on an inpatient basis and discharge occurs within 48 hours after admission for a mastectomy, the plan will cover one home health care visit within 48 hours after discharge, as determined necessary by the attending physician.
2. Reconstruction of the breast on which the mastectomy was performed, including initial and subsequent prosthetic devices to replace the removed breast or portions thereof.
3. Surgery and reconstruction of the other breast to produce a symmetrical appearance. This includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty, and mastopexy.
4. Treatment of physical complications of all stages of the mastectomy, including lymphedemas.

The benefits under this provision will be provided in a manner determined in consultation with the attending physician and the patient, and as provided in the Women's Health and Cancer Rights Act of 1998 which applies to this plan.

Y. Therapy and Rehabilitation Services

The plan covers charges for the following therapy and rehabilitation services when ordered by a physician:

1. Radiation therapy;
2. Chemotherapy;
3. Dialysis treatment;
4. Physical medicine (see definition in *Part II*), up to a combined limit of 36 visits per calendar year*;
5. Respiratory therapy;
6. Occupational therapy, up to a combined limit of 36 visits per calendar year*;
7. Speech therapy, up to a combined limit of 36 visits per calendar year*;
8. Infusion therapy; and
9. Cardiac rehabilitation.

*The combined limit of 36 visits per calendar year applies to acupuncture (see *Section A* of this *Part IX*), physical medicine, speech therapy, and occupational therapy visits.

The plan does not cover therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate.

Z. Transplant Services

Charges for medically necessary and appropriate human organ, bone marrow, blood stem cell, and tissue transplants will be covered as any other illness if the following conditions are met:
1. The procedure or organ transplant is not considered experimental or investigational in nature by any appropriate technological assessment body established by any state or federal government; and
2. Such expenses are not covered under any government or other insurance program.

Organ, bone marrow, and blood stem cell transplants include the following procedures:
1. Heart transplants;
2. Heart/lung transplants;
3. Kidney transplants;
4. Pancreas transplants;
5. Liver transplants;
6. Bone marrow transplants (autologous, allogeneic) or other method of stem cell support, if it is not experimental;
7. Lung transplants (single or double); and
8. Kidney/pancreas transplants from the same donor.

Transplant Expenses

Covered charges for transplants are limited to charges that would qualify as covered expenses under this *Part IX* for:
1. Pre-transplant evaluation,
2. Pre-transplant harvesting,
3. Pre-transplant stabilization,
4. The transplant itself, and
5. Follow-up biopsies and anti-rejection medication.

If a human organ, tissue, or blood stem cell transplant is provided from a living donor to a human transplant recipient, the follow guidelines apply:
1. When both the recipient and the donor are members covered under this plan, each is entitled to the benefits of this plan.
2. When only the recipient is a member, both the donor and the recipient are entitled to the benefits of this plan, subject to the following limitations:
   a. The donor benefits are limited to only those that are not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Shield coverage, or any government program; and
   b. Benefits provided to the donor will be charged against the recipient’s coverage under this plan to the extent that benefits remain and are available under this plan after benefits for the recipient’s own expenses are paid.
3. When only the donor is a member, the donor is entitled to the benefits of this plan, subject to the following limitations:
   a. The donor benefits are limited to only those that are not provided or available to the donor from any other source in accordance with the terms of this plan; and
   b. No benefits are provided to the non-member transplant recipient.
4. If any organ, tissue, or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue, or blood stem cell; however, other costs related to evaluation and procurement of the organ, tissue, or blood stem cell are covered by the plan.

Travel, Lodging, and Food Expenses

If a covered organ, bone marrow, or blood stem cell transplant is performed in a network facility, the plan will cover the following travel, lodging, and food expenses in connection with the transplant:
1. Transportation for the member recipient and one adult to accompany the member recipient to and from the transplant facility;
2. Lodging at or near the transplant facility for the adult who accompanied the member recipient, while the member recipient is confined at the transplant facility; and
3. Food expenses.

Transportation, lodging, and food expenses for the accompanying adult will be limited to $5,000 per covered transplant at the transplant facility.

This transportation, lodging, and food will be provided for:
1. Pre-transplant evaluation, harvesting, and stabilization, and
2. The transplant itself.

These costs will be considered as additional covered expenses. In addition, there will be no deductible or coinsurance amount applied to these expenses.

Travel, lodging, and food benefits are not available for tissue transplants.

Exclusions

No benefits will be paid for human organ, bone marrow, blood stem cell, and tissue transplant charges:
1. That exceed the allowable charges;
2. For animal to human transplants;
3. For artificial or mechanical devices designed to replace human organs temporarily or permanently, unless approved by Highmark;
4. For procurement or transportation of the organ or tissue unless expressly provided for in this provision;
5. To keep a donor alive for the transplant operation; and
6. That are excluded in *Part X* of this summary plan description.

AA. Other Covered Charges

The plan will cover the following types of care, service, and treatment given to a covered person in connection with a covered illness or injury:
1. Charges for medical care, treatment, services, and supplies listed below, when prescribed by the attending physician:
   a. Use of radium or other radioactive substances.
   b. Whole blood or blood derivatives, blood processing, and administration of blood.
   c. Heart pacemaker.
   d. Canes, crutches, and walkers.
   e. Colostomy or ileostomy bags and related supplies.
   f. Allergy extract and allergy injections.
   g. Rental or purchase (at the option of Highmark), adjustment, repair, and replacement of durable medical equipment required for therapeutic use when prescribed by a professional provider, within the scope of his or her license. Examples of durable medical equipment include:
      - a wheelchair
      - a hospital bed
      - an inhalation device
      - a home or portable dialysis system.
   h. Oxygen and equipment for its administration.
2. Charges for elective sterilization for covered males, regardless of medical necessity and appropriateness. Elective sterilization for females is covered under the Adult Preventive Care Services provision outlined in *Part IX, Section Q*.

Part X, Exceptions & Limitations — What Is Not Covered

Although the plan covers charges for most illnesses and injury, there are some conditions and charges it does **not** cover. These are:

A. Illness, Injuries and Other Services

The plan does **not** cover charges for:
1. Services, treatment, or supplies received prior to a member's effective date of coverage under this plan or after a member's coverage under this plan terminates.
2. Services, treatment, or supplies not prescribed by or performed by or upon the direction of a professional provider.
3. Services or treatment submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member.
4. Services or treatment rendered by other than ancillary providers, facility providers, professional providers, or contracting suppliers (see definitions in *Part II*).
5. Services or treatment performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.

6. Services, treatment, or supplies that are not medically necessary and appropriate as determined by Highmark Blue Shield.
7. Services, treatment, or supplies that are experimental or investigative for the condition being treated. That is, procedures and drugs that have not been adopted for general, clinical use and have not been approved by the appropriate boards or are not accepted by the medical community as safe, effective treatment.
8. Charges billed with inappropriate or non-standard codes, as determined by Highmark according to accepted industry billing standards.
9. Services, treatment, or supplies for which you would have no legal obligation to pay if you didn't have coverage under this plan.
10. Completion of claim forms, or failure to keep a scheduled appointment.
11. Treatment of a condition, illness, or injury resulting from or prolonged by a member's involvement in an illegal occupation, performance of, or attempted performance of an assault or other felony.
12. Personal, non-medical services or supplies while hospitalized — for example, television, haircuts, telephone, and newspapers.
13. Personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
14. Reversal of an elective sterilization.
15. A hospital admission in connection with surgery that begins on a Fri., Sat., or Sun. — unless surgery is performed the next day. If a covered person is going to have surgery on Mon., the plan will cover an admission that begins on Sun.
16. Inpatient admissions that are primarily for diagnostic studies.
17. Inpatient admissions that are primarily for physical medicine services.
18. Transplant services other than those listed under *Part IX, Section Z*, unless approved by Highmark.
19. Loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, and loss sustained or expenses incurred as a result of an act of war, whether declared or undeclared. This includes service with military forces as a civilian whose duties do not include combat.
20. Treatment of a condition, illness, or injury that results from participating in a civil insurrection or riot.
21. Treatment required as a result of any illness or injury that occurs in the course of employment or any work for wage or profit (including self-employment) if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.
22. Custodial care, domiciliary care, residential care, protective care, and supportive care, including educational services, rest cures, convalescent care, and care that is chiefly for the purpose of meeting personal needs and could be provided by persons without professional skills or training.
23. Respite care.
24. Services, treatment, or supplies provided to you or a covered dependent by a provider who is a member of your immediate family or someone who ordinarily lives with you.
25. Services, treatment, or supplies provided by a dental or medical department maintained, in whole or in part, by or on behalf of an employer, mutual benefit association, labor union, trust, or similar type of entity.
26. Services, treatment, or supplies to the extent benefits are provided to members of the armed forces or to patients in a hospital or other facility operated by any U.S. governmental agency, including Veteran's Administration facilities for service-connected illness or injury, unless you are obligated by law to pay the charges.
27. Services, treatment, or supplies to the extent payment has been made under Medicare when Medicare is primary.
28. Services or treatment for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law.
29. Ambulance services, except as specifically provided in *Part IX, Section B*.
30. Services, treatment, or supplies directly related to the care, filling, removal, or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy, and treatment of periodontal disease. Exceptions to this exclusion are dental expenses specifically covered in *Part IX, Section F*.
31. Oral surgical procedures, except as specifically covered in *Part IX, Section F*.
32. Tooth implantology.
33. Treatment of temporomandibular joint syndrome (TMJ) with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion; and treatment of TMJ not caused by documented organic joint disease or physical trauma.

34. Cosmetic surgery performed to improve the appearance of any portion of the body and from which no improvement in physiological function can be expected, except as specifically provided in this plan. Other exceptions include cosmetic surgery to correct:
    a. A condition resulting from an accident;
    b. A congenital defect; and
    c. A functional impairment that results from a covered disease or injury.
35. Palliative, or cosmetic foot care, including but not limited to flat foot conditions; supportive devices for the foot; corrective shoes; treatment of subluxations of the foot; care of corns, bunions (except capsular or bone surgery), calluses, toenails (except surgery for ingrown toenails); fallen arches; weak feet; chronic foot strain; and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
36. Routine hearing services.
37. Hearing aids, tinnitus maskers, or examinations for the prescription or fitting of hearing aids.
38. Routine optometric vision examinations.
39. Eyeglasses, contact lenses, and vision examination for prescribing or fitting eyeglasses or contact lenses. Exceptions to this exclusion are:
    a. The initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses; and
    b. Sclera shells intended for use in the treatment of illness or injury.
40. Correction of myopia, hyperopia, or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK), and all related services.
41. Routine or periodic physical examinations not necessary for the treatment of an injury or illness, except as specifically provided in *Part IX, Section Q.* The plan does not cover the completion of forms and preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, such as employment physicals, pre-marital examinations, and physicals for school, camp, sports, or travel, which are not medically necessary and appropriate.
42. Preventive care services and wellness services or programs, except as specifically provided in *Part IX, Section Q*.
43. Well-baby care visits, except as specifically provided in *Part IX, Section Q*.
44. Nicotine cessation support programs and/or classes, except as specifically provided in *Part IX, Section Q*.
45. Any care related to conditions such as autism, hyperkinetic syndromes, learning disabilities, behavioral problems, or intellectual disabilities that extends beyond traditional medical management. Care that extends beyond traditional medical management includes the following:
    a. Services that are primarily educational in nature;
    b. Neuropsychological testing and educational testing (such as I.Q., mental ability, achievement, and aptitude testing), except for specific evaluation purposes directly related to medical treatment;
    c. Services related to learning disorders or learning disabilities;
    d. Services provided primarily for social or environmental change unrelated to medical treatment;
    e. Developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and
    f. Services provided for which, based on medical standards, there is no established expectation of achieving measurable improvement in a reasonable and predictable period of time.
46. Treatment for conditions that do not meet the level of impairment or symptoms required to be medically necessary such as, but not limited to:
    a. Partnership relationship problems;
    b. Marital counseling (if no mental health diagnosis);
    c. Parent-child problems; and
    d. Academic problems.
47. Methadone hydrochloride treatment for which no additional functional progress is expected to occur.
48. Services or treatment ordered by a court or other judicial proceedings as part of the member's sentence, even if otherwise covered by the plan.
49. Services, treatment, or supplies that have been disallowed under the provisions of the Healthcare Management Services (HMS) precertification program.
50. Elective abortions for any reason other than to preserve the person's life upon whom the abortion is performed.
51. Immunizations required for foreign travel or employment.
52. Surrogate pregnancy.
53. Treatment of sexual dysfunction not related to organic disease or injury.
54. Treatment provided specifically for the purpose of assisted fertilization, except as provided in *Part IX, Section M*.
55. Drugs not approved by the U.S. Food and Drug Administration for sale in the U.S.
56. Outpatient prescription drug charges — unless the *Outpatient Prescription Drug Rider* is attached to this summary plan description.

57. Nutritional counseling, except as specifically provided in *Part IX, Section Q,* for prevention of obesity.
58. Food including, but not limited to, enteral formulae, infant formulas, supplements, substances, products, enteral solutions, or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition, and when provided on an outpatient basis, except as specifically provided for enteral formulae in *Part IX, Section I*.
59. Medical or surgical treatment of obesity or morbid obesity, even if prescribed or provided by a physician.
60. Supplies, instructions, programs, and activities for weight reduction (including all diagnostic testing related to weight reduction programs), weight control, or physical fitness, even if prescribed or provided by a physician.
61. Any other medical or dental service or treatment except as specifically provided by this plan.

B. Claims Submitted After Loss of Dependent Eligibility

Claims will not be paid for your children who are no longer eligible to be covered under this plan as your dependents. Please read *Part III, Section B*, and *Part XIV* for more information on dependent eligibility and when coverage ends under this plan.

Part XI, About Your Identification Card

The Blue Shield symbol on your Highmark PPO identification (ID) card is recognized throughout the country and around the world. You should carry your ID card with you at all times, destroy any previously issued medical ID cards, and show this card to the hospital, physician, or other professional provider whenever you or your covered dependents need medical care.

When you or one of your covered dependents receives health care services, you need to show your ID card to the hospital, physician, or other professional provider and ask the provider to file the claim for you.

The following information is displayed on your ID card:
1. Your name;
2. Your identification number;
3. Group number;
4. Copayment for physician office visits and emergency room visits;
5. Member Service toll-free number (on back of the card);
6. Precertification toll-free number (on back of card); and
7. “PPO in Suitcase” symbol.

There is a logo of a suitcase with “PPO” inside it on your ID card. This “PPO suitcase” lets hospitals, physicians, and other professional providers know that you are a member of a Blue Shield PPO and that you have access to PPO providers nationwide.

If your card is lost or stolen, please contact Highmark Member Service immediately. To request additional ID cards, you may contact Highmark Member Service or request cards online by logging in to www.highmarkblueshield.com.

Part XII, How to File a Claim

A. When Receiving Services from a Network Provider

If services are received from a network provider, you will not have to file a claim. You need to make sure you show the member’s ID card to the provider. The provider will take the information needed and will then bill the plan. Any ineligible and unpaid services will be billed to you by the network provider.

B. When Receiving Services from an Out-of-Network Provider

If services are received from an out-of-network provider, you or your provider must file a paper claim form before the plan can pay charges for a member’s care, service, or treatment. You cannot combine claims for more than one family member on the same claim form. A separate claim form will need to be submitted for each member with a claim. Multiple services for the same member can be filed on the same claim form.

It is your responsibility to make sure that appropriate claim forms are properly completed, signed, and dated and mailed to Highmark at the address listed on the back of your ID card. You can get paper claim forms from the plan

representative, Highmark Member Service, or the Highmark website at www.highmarkblueshield.com. If you have questions about how to fill out the form, please talk to the plan representative.

To be considered for payment, all paper claims must be filed within one year from the end of the year in which the service took place. Claims filed more than one year after the end of the year in which the service took place are not eligible for coverage.

Note: The Outbreak Period is disregarded when determining the deadline for submission of a claim. The Outbreak Period is the period that began March 1, 2020 and ends 60 days after the announced end of the COVID-19 national emergency.

When you submit a claim form, you must attach the itemized bill. **It is important to send in original bills. "Balance due" statements, paid receipts, or canceled checks cannot be used because they do not give Highmark enough information to process the claim correctly.** The following information must be included on the itemized bill:

1. The name and address of the provider;
2. The patient's full name;
3. The date of the service or supply;
4. A description of the service or supply;
5. The amount charged;
6. The diagnosis of the illness, injury, or condition;
7. For durable medical equipment, the physician's certification;
8. For private duty nursing, the nurse's license number, charge per day, shift worked, and signature of provider prescribing the service; and
9. For ambulance services, the total mileage.

If you have already made payment for the services received, you must also submit proof of payment (receipt from the provider) with the claim form.

C. Initial Post-Service Claim Determination

Highmark will notify you in writing of its determination of your post-service claim within a reasonable period of time, but no later than 30 days after Highmark receives the claim. However, Highmark may extend the review period once for an additional 15 days if Highmark determines additional time is necessary due to special circumstances beyond its control. If an extension of time is required, Highmark will notify you of the extension prior to the end of the initial 30-day post-service claim determination period. This extension notification will be communicated to you in writing and will include the reason for the delay and the date a determination is expected.

If an extension of time is necessary because Highmark needs additional information from you to decide the post-service claim, the extension notice will describe the specific information you need to submit to the plan to complete the claim. In this event, you will be given at least 45 days from the day you receive the extension notice to provide the required information before a decision is made on your post-service claim. The 45-day extended time frame in which Highmark is required to make a determination on your post-service claim will not include the days from the date of the extension notice to the earlier of:

1. The date Highmark receives the requested information; or
2. The date the requested information is required to be provided to Highmark.

After a post-service claim is processed, you will receive an *Explanation of Benefits* (EOB) statement in writing. Please read it carefully so you will understand how the claim has been paid. This form lists:

1. The provider's actual charges;
2. The allowable amount, as determined by Highmark;
3. Copayment amounts;
4. Deductible and coinsurance amounts you are required to pay, if any;
5. Total benefits payable by the plan; and
6. The total amount you are required to pay.

If a post-service claim is denied (in whole or in part), you will receive written notification of the adverse benefit determination which will include specific information about the denied claim and the plan's appeal procedures, as outlined in *Part XIII*.

Part XIII, Appeal Procedures

NOTE: The Outbreak Period is disregarded when determining the deadline for appeals of adverse benefit determinations, requests for external review, and completion of an incomplete request for external review. The Outbreak Period is the period that began March 1, 2020 and ends 60 days after the announced end of the COVID-19 national emergency.

A. Notification of Initial Adverse Benefit Determination

You will be notified of an initial adverse benefit determination in writing when:
1. A pre-service or post-service claim for benefits is denied (either in whole or in part);
2. A concurrent care request for extension of a previously approved admission or treatment is denied;
3. A concurrent care review decision is made to reduce or terminate previously approved benefits provided over a period of time; or
4. Plan coverage is rescinded, as outlined in *Part XX, Section G,* except for rescission of coverage due to failure to timely pay required premium contributions.

You will be notified orally of any initial adverse benefit determination involving an urgent care claim for benefits. In this case, written confirmation of the decision will be provided to you within three days after the oral notification.

The notification of an initial adverse benefit determination will be provided to you by Highmark if the adverse benefit determination relates to medical services and by Everence if the adverse benefit determination relates to prescription drugs.

The notification of an initial adverse benefit determination will include the following information:
1. The specific reason or reasons for the adverse benefit determination;
2. Reference to the specific plan provisions on which the adverse benefit determination was based;
3. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;
4. A description of the plan's appeal procedures and the time limits applicable to such procedures;
5. Your right to receive a copy of the internal rule, guideline, protocol, or similar criteria, free of charge upon request, if an internal rule, guideline, protocol, or similar criteria was relied on in making the adverse benefit determination;
6. Your right to receive an explanation of any scientific or clinical judgment of the plan in applying the terms of the plan to your medical circumstances, free of charge upon request, if the adverse benefit determination is based on medical necessity, experimental treatment, or other similar exclusion; and
7. An explanation of the plan's expedited review process for an urgent care claim.

If the reason for an initial adverse benefit determination is unclear to you, please contact Highmark for clarification if the initial adverse benefit determination relates to medical services and Everence if the initial adverse benefit determination relates to prescription drugs.

B. First Level Appeal of Initial Adverse Benefit Determination

If, after talking with Highmark or Everence, your question or concern about the adverse benefit determination is not addressed to your satisfaction, or if you do not agree with the initial adverse benefit determination, you may appeal the decision. You have the right to designate an individual to act on your behalf as your authorized representative in connection with any claim for coverage or benefits. Highmark and Everence reserve the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

To appeal an initial adverse benefit determination, you or your authorized representative must submit a written request for review of the adverse benefit determination to Highmark (medical services) or Everence (prescription drugs). The written appeal must be received within the following applicable timeframe after you receive notice of the initial adverse benefit determination:
1. 180 days for a pre-service, urgent care, or post-service claim; or rescission of coverage appeal; and
2. Prior to the termination of the admission or treatment for a concurrent care claim.

To expedite the review of an adverse benefit determination involving an urgent care claim, you or your authorized representative may telephone Highmark or Everence to request the review instead of submitting a written appeal.

You will be provided with a full and fair review of the initial adverse benefit determination. This means:

1. The review will be conducted by a representative from the Highmark Appeal Review Department or Everence who was not involved in any previous decision to deny the claim which is the subject of your appeal or the subordinate of any individual who was involved in that decision;
2. The independence and impartiality of those involved in the review will be maintained;
3. The claim and all documentation supporting it will be re-examined during the review and the Highmark Appeal Review Department or Everence will afford no deference to any prior adverse decision on the claim which is the subject of your appeal;
4. If you are appealing an adverse benefit determination that was based on a medical judgment, including whether a requested benefit is medically necessary and appropriate or experimental or investigative, the Highmark Appeal Review Department or Everence will consult with a physician of the same or similar specialty. The physician must not be the same individual who was consulted in connection with the initial determination or a subordinate of that individual;
5. Upon your request, you will be provided with the identity of any medical or vocational expert whose advice was obtained in connection with the initial adverse benefit determination;
6. You will be given the opportunity to submit written comments, documents, records, etc., with regard to your claim for benefits. All information you submit will be taken into account during the review, regardless of whether it was reviewed as part of the initial determination; and
7. You are entitled to receive upon request and free of charge, copies of all documents, records, and information relevant to your claim for benefits; and
8. Any new or additional evidence or rationale considered or relied on in denying the claim will be provided to you sufficiently in advance of the due date for the Highmark Appeal Review Department or Everence's decision to allow you sufficient time to respond prior to the decision.

You will be notified of the review decision as soon as possible after Highmark or Everence receive your appeal of the adverse benefit determination, but no later than:

1. 72 hours for an urgent care claim;
2. 30 days for a non-urgent pre-service claim;
3. 30 days for a post-service claim;
4. 30 days for a rescission of coverage appeal; and
5. Prior to termination of the admission or treatment for a concurrent care claim.

The notification will be provided in writing for a pre-service, concurrent care, or post-service claim; or rescission of coverage appeal; and orally for an urgent care claim. When the notification is provided orally, written confirmation of the decision will be provided to you within three days after the oral notification.

C. Notification of First Level Appeal Adverse Benefit Determination

If the review of your appeal of an initial adverse benefit determination again results in an adverse benefit determination, the notification to you will include the following information:

1. The specific reason or reasons for the adverse benefit determination on review;
2. Reference to the specific plan provisions on which the adverse benefit determination is based;
3. Notification of your right to receive, free of charge upon request, any document:
   a. Relied on in making the determination;
   b. Submitted, considered, or generated in the course of making the determination;
   c. That demonstrates compliance with the administrative processes and safeguards required in making the determination; or
   d. That constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment without regard to whether the statement was relied on.
4. Your right to receive a copy of the internal rule, guideline, protocol, or similar criteria free of charge upon request, if an internal rule, guideline, protocol, or similar criteria was relied on in making the adverse benefit determination;
5. Your right to receive an explanation of any scientific or clinical judgment of the plan in applying the terms of the plan to your medical circumstances, free of charge upon request, if the adverse benefit determination is based on medical necessity, experimental treatment, or other similar exclusion; and
6. Notification of your right to file a second level appeal.

D. Second Level Appeal of First Level Appeal Adverse Benefit Determination

If your first level appeal of an initial adverse benefit determination is denied, you have the right to request a second level review. The second level review will be facilitated by Everence and will be decided by the plan administrator

according to the full and fair review procedures outlined in *Section B* above. To request a second level appeal, you must submit a written request for a second level claim review to Everence within 30 days after the date you receive notice of the first level review decision.

Everence will provide you with written notification of the plan administrator's review decision of your second level appeal within 30 days after the second level appeal is received by Everence.

E. Notification of Second Level Appeal Adverse Benefit Determination

If the plan administrator's review of your second level appeal of a first level appeal adverse benefit determination again results in an adverse benefit determination, the notification to you will include the information listed in items #1 through #5 in *Section C* above. The notification will also include information about your right to request external review of the adverse benefit determination, as outlined in *Section F,* including contact information for requesting external review.

You cannot file a lawsuit on any adverse benefit determination unless you have exhausted the appeal procedures outlined above. You also cannot file a lawsuit on any adverse benefit determination more than three years after the care, service, or treatment has been given to you or your covered dependent.

F. External Review

If you have exhausted the plan's internal appeal procedures and your second level appeal of an adverse benefit determination is denied by the plan administrator, you may have the right to further appeal the denial through the independent external review process established under the Patient Protection and Affordable Care Act (ACA).

External review is available if the final adverse benefit determination of a second level appeal is based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, a determination that treatment is experimental or investigational, or a determination by the plan administrator to rescind plan coverage. External review is not available if the adverse benefit determination is based on a plan participant's failure to meet eligibility requirements under the terms of the plan (other than eligibility disputes related to rescission of coverage), explicit benefit exclusions, or defined benefit limits.

You must file your request for external review with Highmark (medical services) or Everence (prescription drugs) within four months after you receive notification of the final adverse benefit determination of your second level appeal. For pre-service claims, the four-month period begins to run from the date you received notification of the initial adverse benefit determination. The external review will be conducted by an independent review organization that is not affiliated with the plan.

Preliminary Review

A preliminary review of your external review request will be conducted within five business days following the date the request is received. The preliminary review will determine whether:

1. You were covered by the plan at all relevant times;
2. The adverse benefit determination relates to your failure to meet the plan's eligibility requirements;
3. You exhausted the plan's internal appeal process outlined above; and
4. You submitted all required information or forms necessary for processing the external review.

You will be notified of the results of the preliminary review within one business day following completion of the review. If your request is complete but not eligible for external review the notification will include the reasons for ineligibility. If your request is not complete, the notification will describe the information or materials needed to complete the request. You will have the remainder of the four-month filing period or if later, 48 hours from receipt of the notifications, whichever is later, to complete your request for external review.

Referral to Independent Review Organization (IRO)

If your request for external review is found to be acceptable following preliminary review, one of at least three IROs will randomly or by rotation be selected to perform an external review of your claim. The IRO will be accredited by a nationally recognized accrediting organization. Within five business days thereafter, Highmark or Everence will provide the IRO with documents and information the plan administrator considered when making the final internal adverse benefit determination. The IRO may reverse the plan administrator's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day timeframe. If the IRO does so, it will notify you and the plan within one business day after making the decision.

The IRO will timely notify you in writing of the eligibility of your request for external review and will provide you with at least 10 business days following receipt of the notice to provide additional information for the IRO to consider in its external review.

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim *de novo*. This means the IRO will not be bound by any decisions or conclusions reached during the plan's internal claims and appeal process outlined above.

The assigned IRO must provide written notice of its final external review decision within 45 days after the date the IRO received the request for external review. The IRO will deliver its notice of final external review decision to you and Highmark or Everence. The IRO's notice will include the following:

1. A general description of the reason for the external review request, including information sufficient to identify the claim;
2. The date it received the assignment to conduct the review and the date of its decision;
3. References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
4. A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either you or your plan;
6. A statement that judicial review may be available to you; and
7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon Highmark or Everence's receipt of the IRO's notice of a final external review decision from the IRO that reverses the plan administrator's prior final internal adverse benefit determination.

Expedited External Review

You are entitled to external review as described above on an expedited basis if:

1. The final adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal;
2. You have a medical condition where the timeframe for completion of a standard external review of a final internal adverse benefit determination would seriously jeopardize your ability to regain maximum function; or
3. The final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from the facility rendering emergency services.

In the above circumstances, Highmark or Everence will immediately conduct a preliminary review and will immediately notify you if your request is not eligible. If your request is not complete, the notification will describe the information or materials needed to complete the request. You will then have 48 hours from receipt of the notice to complete your request for external review.

If your request for external review on an expedited basis is found to be acceptable following Highmark or Everence's preliminary review, the external review will be conducted by the IRO according to the same procedures outlined above for external review that is not expedited. However, the assigned IRO must provide notice of its final external review decision as expeditiously as possible, but in no event more than 72 hours from the time the IRO received the request for external review. The IRO must provide written notice of its final external review decision to you and to Highmark or Everence, if not originally in writing, within 48 hours of its original decision. The IRO's written notice will inform you of the same information listed above for the final external review decision of a non-expedited external review.

Coverage or payment for the requested benefits will be paid immediately upon Highmark or Everence's receipt of the IRO's notice of a final expedited external review decision from the IRO that reverses the plan administrator's prior final internal adverse benefit determination.

Part XIV, When Coverage Ends

Plan coverage will end at midnight on the first of the following events:
1. The day you cease to be eligible for coverage under this plan as a full-time employee due to a change in your hours of employment with your member organization, pursuant to your member organization's Eligibility Policy;
2. The termination of employment ending date of coverage listed in the *Schedule of Benefits* when your employment with the member organization terminates voluntarily, involuntarily, or due to your death.
3. The last day of an approved leave of absence (including a leave that qualifies under the Family and Medical Leave Act of 1993), if you do not return to work as an active employee on the first business day that follows the last day of the leave;
4. The last day of coverage for which you authorized or paid any required premium contribution;
5. The day your member organization is no longer eligible to participate in the plan;
6. The day your member organization terminates participation in the plan; or
7. The day the plan sponsor discontinues the plan for all plan participants.

Coverage for an employee's dependents will end the same day the employee's coverage ends or if earlier, the day they no longer qualify as a dependent, with the following exceptions:
1. Coverage for a dependent child who reaches the age limit outlined in *Part III* will end the last day of the month in which the age limit is reached; and
2. In the event of an employee's death, coverage for the employee's dependents will end the last day of the month of the employee's death.

Plan coverage will end as described above unless you or your dependents choose to continue coverage entirely at your own cost as allowed under *Part XV*.

Part XV, Continuation of Coverage

You and your dependents may choose to continue coverage under this plan, at your own expense, under certain circumstances that would ordinarily end your coverage (see *Part XIV*).

When group health plan coverage under this plan ends and you become eligible for continuation of coverage, you may also be eligible for other coverage options that may cost less than continuation coverage, as outlined in *Section G* of this *Part XV*.

A. Eligibility Requirements

You and your covered dependents can choose to continue coverage if group health coverage under the Friends Mutual Health Group Plan is lost as a result of any of the following qualifying events:
1. Your employment with your member organization terminates for any reason other than acts of "gross misconduct";
2. Reduction in your hours of employment with your member organization such that you are no longer eligible for coverage under this plan as a full-time employee, pursuant to your member organization's Eligibility Policy; or
3. You do not return to work as an active employee on the first business day that follows the last day of an approved leave of absence (including a leave that qualifies under the Family and Medical Leave Act of 1993).

Your covered dependents may also choose to continue coverage if they are no longer eligible for group health coverage under the Friends Mutual Health Group Plan as a result of any of the following qualifying events:
1. Your death;
2. You and your spouse divorce or legally separate;
3. You and your domestic partner terminate your domestic partnership;
4. You become enrolled in Medicare (Part A, Part B, or both); or
5. They no longer qualify as an eligible dependent, according to the terms of the plan.

B. Employee and Employer Rights and Responsibilities

The plan will offer continuation of coverage to you and your covered dependents only after the plan has been notified that a qualifying event has occurred.

Your member organization is required to notify the plan within 30 days after coverage for an employee and his or her covered dependents would be lost because of any of the following qualifying events:

1. Reduction in an employee's hours of employment with the member organization such that the employee is no longer eligible for coverage under this plan as a full-time employee, pursuant to the member organization's Eligibility Policy;
2. Failure of an employee to return to work as an active employee on the first business day that follows the last day of an approved leave;
3. Termination of an employee's employment with the member organization for reasons other than gross misconduct;
4. Death of an employee; or
5. Entitlement of an employee to Medicare (Part A, Part B, or both).

The employee or the employee's dependent is responsible to notify the plan as soon as possible, but no later than 60 days after plan coverage for the employee's dependent would be lost because of any of the following qualifying events:

1. The employee and spouse divorce;
2. The employee and spouse legally separate;
3. The employee and domestic partner terminate their domestic partnership; or
4. A child no longer qualifies as the employee's dependent, according to the terms of the plan.

You or your dependent must provide notice of a qualifying event to the plan by completing and returning the required cancellation form to your plan representative. This form can be obtained from the plan representative. If you or your dependent do not provide notice of a qualifying event to the plan representative within 60 days after coverage would otherwise be lost because of the qualifying event, you and your dependents will lose all continuation coverage rights under the plan.

Within 14 days after receiving notice that a qualifying event has occurred, continuation of coverage will be offered to all eligible individuals. You and/or your eligible dependents have a maximum of 60 days from the date of notification of continuation of coverage rights to elect continuation of coverage. Continuation of coverage will begin on the day plan coverage would otherwise end due to the qualifying event for each eligible individual who elects continuation of coverage within the 60-day election period. If an eligible individual does not elect continuation of coverage within the 60-day election period, group health coverage under the Friends Mutual Health Group Plan will end and the individual will lose all continuation of coverage rights under the plan.

Each eligible individual has an independent right to elect continuation of coverage. However, if not otherwise indicated when you elect continuation of coverage, the election will be deemed to be an election on behalf of all eligible individuals who would have lost coverage because of the qualifying event giving rise to the election.

You are responsible to keep your member organization informed of all events that they might otherwise not be aware of (such as information about your dependents) regarding your family's continuation of coverage rights. In order to protect your family's rights, you should also keep your member organization informed of any changes in the address of family members. You should keep a copy of any notices you send to your member organization for your records.

C. Length and Level of Coverage

Continuation of coverage will be the same coverage that the Friends Mutual Group Health Plan provides to other plan participants who are not receiving continuation of coverage. Each individual who elects continuation of coverage will have the same rights and benefits under the plan as other plan participants, including open enrollment and special enrollment rights.

In the case of loss of coverage due to an employee's death, divorce or legal separation, termination of a domestic partnership, or Medicare entitlement; or a child ceasing to be eligible for coverage as a dependent under the terms of the plan, coverage may be continued for up to 36 months.

In the case of loss of coverage due to an employee's termination of employment (for reasons other than gross misconduct) or reduction in hours of employment, coverage may be continued for up to 18 months.

This 18 months may be extended to 36 months for spouses/domestic partners and dependent children who elect continuation of coverage if a second qualifying event occurs during that 18-month period. Such second qualifying events include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's entitlement to Medicare (Part A, Part B, or both), and a dependent child losing eligibility for coverage

under the plan as a dependent. An employee's entitlement to Medicare qualifies as a second qualifying event for the employee's spouse/domestic partner and dependents only if, under the terms of the plan, they would have lost eligibility for plan coverage as a result of an employee's entitlement to Medicare while actively employed. You or your dependent must notify the plan within 60 days after a second qualifying event occurs. Failure to provide notice of a second qualifying event as required will result in loss of the right to extend the period of continuation of coverage because of a second qualifying event.

If a covered person is deemed to be disabled (for Social Security disability purposes) at the time of a qualifying event or any time during the first 60 days of continuation of coverage, the 18 months may be extended to 29 months for the individual and his or her covered spouse/domestic partner and dependent children. You must submit a copy of the Social Security Administration's disability determination letter to your member organization within 60 days after the date of the disability determination and before the end of the original 18-month continuation period. The disabled individual must also notify the member organization within 30 days after any final determination by the Social Security Administration that the individual is no longer disabled. Failure to provide notice of the Social Security Administration's determination of disability to your member organization as required will result in loss of the right to extend the period of continuation coverage because of disability.

In no event will continuation of coverage last beyond 36 months from the date of the qualifying event that originally made a covered person eligible to elect continuation of coverage.

D. Cost of Continuation Coverage

Generally, each individual electing continuation of coverage is required to pay the entire cost of continuation coverage plus a two percent surcharge for administrative expenses. The amount an individual is required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant who is not receiving continuation of coverage. The cost of continuation coverage for a spouse or child who no longer qualifies as the employee's dependent will be the same as the cost of continuation coverage for a single employee.

The notice telling you about continuation of coverage will also include the monthly cost. The cost of coverage is determined each year just before the beginning of the plan year (Jan. 1). It is based on the amount paid for claims during the year, insurance costs, and the cost to administer the plan. Plan costs are adjusted once each year and remain the same for the entire plan year.

E. Payment of Premium

If you and/or your covered dependents elect continuation of coverage, payment for continuation of coverage is not required to be sent with the election form. However, the first payment for continuation of coverage must be made within 45 days after the date of election. If the election form is returned by mail, the date of election is considered to be the post-marked date. If you or your dependents do not make the first payment for continuation of coverage within 45 days after the date of election, you and/or your dependents will lose all continuation of coverage rights under the plan.

The first payment must cover the cost of continuation of coverage from the day coverage under the plan would otherwise have terminated up to the time the first payment is made. The amount of the first payment, the due date, and the address where payment must be sent will be listed on the election form. You or your dependents are responsible to make sure the amount of the first payment is enough to cover this entire period. You may contact the plan representative to confirm the correct amount of the first payment.

After the first payment is made, continuation of coverage is required to be paid on a monthly basis. Payment for continuation of coverage is due on the first day of each month. If payment is made on or before the due date, coverage under the plan will continue for that month without any break. The plan will send a monthly premium notice that lists the amount of the required payment and the due date. The monthly payment should be sent to the address on the premium notice.

Although payment for continuation of coverage is due on the first day of each month, you and/or your dependents will be given a grace period of 30 days to make each monthly payment. Coverage will continue during the grace period as long as the monthly payment is made before the end of the grace period. If a monthly payment is paid later than the due date but before the end of the grace period for that payment, continuation of coverage will be suspended as of the due date and then retroactively reinstated back to the due date when the payment is made. This means that any claim

for benefits submitted while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

If you or your covered dependents fail to make a monthly payment before the end of the grace period for that payment, coverage will end and you and/or your dependents will lose all rights to continuation of coverage under the plan.

F. Termination of Continuation of Coverage

Continuation of coverage may be terminated before the maximum allowed coverage period for any of the following reasons:
1. Your member organization no longer provides group health plan coverage to any of its employees;
2. The premium for continuation of coverage is not paid by the due date or within the applicable grace period;
3. A covered person becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have*;
4. A covered person becomes entitled to Medicare (Part A, Part B, or both); or
5. Coverage is extended for up to 29 months due to disability and there has been final determination that the individual is no longer disabled.

*(note: there are limitations on plans imposing a pre-existing condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act).

G. Other Coverage Options

When group health plan coverage ends and you become eligible for continuation coverage, you and your family may also be eligible for other coverage options. 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 and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for continuation coverage does not limit your eligibility for coverage or for a tax credit through the Marketplace. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). Some of these coverage options may cost less than continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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.

H. Other Information

This benefit requires your member organization to keep careful records on all employees and their dependents. Remember, it is your responsibility to let the plan representative know when any of your personal information changes, such as your address, your marital status, the number of dependents you have, their names and birth dates, etc.

If you and/or your dependent do not elect continuation coverage, group health coverage under this plan will end.

If you have any questions about continuation coverage, please contact your plan representative. For more information about your rights under the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act (Affordable Care Act), and other laws affecting group health plans, visit the nearest Regional or District Office of the U.S. Dept. of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa/consumer_info_health.html. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA website.) For more information about the Health Insurance Marketplace, visit www.healthcare.gov.

Part XVI, Coordination of Benefits

If you or someone in your family are covered by this plan and another health plan or any other insurance, the two plans coordinate benefits. If more than two plans are involved, all plans will be taken into account. The intent is to avoid paying twice on the same service while providing covered individuals with the benefits outlined in this summary plan description.

To coordinate benefits, one plan (the primary plan) pays benefits first, and the other plan (the secondary plan) pays if there are allowable expenses not paid by the first plan.

A. Definition of Plan

To coordinate benefits, a plan is defined as providing benefits, treatment, or services for medical or dental care. It includes the following:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, grants to states for Medical Assistance Programs of the U.S. Social Security Act, as amended from time to time).
3. Motor vehicle insurance (including no-fault auto insurance).

Each contract or other arrangement for coverage under #1, #2, or #3 is a separate plan. Also, if an arrangement has two parts and coordination of benefit rules apply to only one of the two, each of the parts is a separate plan.

Medicaid is not a plan under this provision.

B. Determining Which Plan is Primary

The following plans or programs will be deemed to be primary:

1. Plans that do not have a coordination of benefits provision;
2. Coverage that is required by law; and
3. Motor vehicle insurance coverage.

Otherwise, one of the following rules will apply.

If Covered under One Plan as an Employee and Another Plan as a Dependent

If you are covered by one plan as an employee, member, or subscriber, and by another plan as a dependent, the plan you are covered by as an employee will be the primary plan.

If you are covered under a retiree plan, are on Medicare, and also have coverage as a dependent on your working spouse's plan, then:

1. The plan covering you as a dependent on your spouse's plan is the primary plan;
2. Medicare pays second; and
3. The plan covering you as a retiree pays last.

Active/Inactive Employee

The benefits of a plan that covers a person as 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. The same would hold true if a person is a dependent of a person covered as a retiree and as an employee. If the plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage

If a person whose coverage is provided under a right of continuation provided by federal or state law is also covered under another plan, the order of benefits will be determined as follows:

1. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
2. Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the plan that covered an employee, member, or subscriber longer is the primary plan.

If a Dependent Is living with Both Parents and Has Coverage under Both Parents' Plans

1. The plan of the parent whose birthday falls earlier in a year will be the primary plan.
2. If the parents have the same birthday, the plan that has covered the parent the longest will be the primary plan.

If a Dependent's Parents are Divorced or Separated and the Dependent Has Coverage under Two Plans

Determining the primary plan is done in the following order:

1. If a court has decreed that one parent is responsible for the health care expenses of the child, that parent's plan will be primary;
2. If a court has awarded joint custody without specifying who has responsibility for the child's health care expenses, the birthday rule will apply;
3. If there is no court ruling as stated in #1 and #2, the plan of the parent with custody will be primary;
4. Next, the plan of the spouse of the parent with custody will be primary;
5. Finally, the plan of the parent not having custody will be primary.

C. When This Is the Primary Plan

Benefits will be paid as described in this summary plan description.

D. When This is the Secondary Plan

The plan will pay benefits only on allowable expenses that have not already been paid by the primary plan.

E. General Provisions

Definition of Allowable Expenses

An allowable expense means a necessary, reasonable, and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. Outpatient prescription drugs are not included as an allowable expense.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

Claim Determination Period

The claim determination period is a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or any part of a year before the date this coordination provision or a similar provision takes effect.

Right to Exchange Information with the Other Plan

To coordinate benefits, Highmark has the right to exchange information with the other plan and require you to supply any information needed. In addition, Highmark may pay other plans any amounts found necessary and deem these payments as paid benefits.

Benefits Other than Cash

If the primary plan offers benefits other than cash, Highmark will assign these a reasonable cash value and regard them a paid benefit.

Overpayment of Benefits

If as a result of this coordination of benefits provision, the amount of benefits paid by this plan on behalf of you or your dependents is more than should have been paid, Highmark may recover the overpayment on behalf of this plan. Highmark may recover the overpayment from:

1. You,
2. Your dependents,
3. Insurance companies, or
4. Other organizations.

Part XVII, Administration of the Plan

Any authority or responsibility allocated to or reserved by the plan administrator shall be exercised by the Friends Mutual Health Group (FMHG). The plan administrator may delegate its responsibilities to other persons or entities.

A. Plan Sponsor

The plan sponsor of the plan is the Friends Mutual Health Group.

The plan sponsor does not guarantee the payment of any benefits under the plan and does not assume any financial risk or obligation with respect to claims submitted to the plan.

B. Plan Administrator

The Friends Mutual Health Group is the plan administrator of the plan and as such shall administer the plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of the plan that the plan administrator shall have maximum legal discretionary authority to construe and interpret eligibility for benefits, 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 will be applied in the same way to all plan participants regardless of special circumstances and will be final and binding on all interested parties.

The duties of the plan administrator include, but are not limited to the following:

1. Requiring any plan participant to furnish such information as it may reasonably request for the purpose of the proper administration of the plan as a condition to receiving any benefit under the plan;
2. Keeping and maintaining plan documents, accounts showing the fiscal transactions of the plan, and all other records pertaining to the plan;
3. Designing and approving plan provisions;
4. Ratifying or establishing practices and procedures relevant to the plan;
5. Authorizing and implementing the amendment or termination of the plan;
6. Administering the plan in accordance with its terms and conditions;
7. Interpreting all provisions of the plan and remedying ambiguities, inconsistencies, errors, or omissions;
8. Hearing and deciding all eligibility and enrollment questions and appeals concerning the plan;
9. Hearing and deciding all second level appeals of denied claims for the plan;
10. Performing all necessary reporting;
11. Maintaining funds for the plan that are sufficient at all times for payment of plan benefits;
12. Directing all payments to be made pursuant to the plan;
13. Securing legal review of plan documents, as necessary, and securing all legal determinations relating to the implementation and administration of the plan, as necessary and appropriate;
14. Contracting with third party providers to provide services deemed appropriate under the plan and monitoring their performance; and
15. Exercising all other functions not specifically delegated to others by the terms of the plan as may be necessary for the proper operation of the plan.

C. Member Organizations

The duties of member organizations shall include, but are not limited to the following:

1. Establishing, communicating, and implementing procedures to determine whether a medical child support order is qualified;
2. Supplying plan participants with plan information (such as this summary plan description);
3. Determining the eligibility of employees and their dependents to enroll in the plan;
4. Reporting to Everence any change in the enrollment status of an employee no later than 15 days following an employment or special enrollment event that affects the employee's eligibility to participate in the plan. Such events include, but are not limited to commencement or termination of employment (voluntary or involuntary), death of an employee, increase or decrease in an employee's hours of employment, commencement or termination of an approved leave of absence, etc.;
5. Reporting to Everence the enrollment of an employee's new dependents added through marriage, birth, or adoption no later than 15 days following the date of marriage, birth, or adoption;
6. Reporting to Everence the enrollment of an employee's dependent(s) as a result of special enrollment rights no later than 15 days following the special enrollment qualifying event; and
7. Reporting to Everence the termination of plan coverage for an employee's dependent no later than 15 days following the date of loss of eligibility.

The plan is responsible for all benefits paid by Highmark on behalf of a covered person that are incurred after the individual's termination date of coverage but prior to the date Highmark is notified of the termination.

D. Claims Administrator

The claims administrator shall be appointed by the plan administrator and shall have the authority and responsibility to provide administrative services in connection with the payment of claims. Highmark is under contract with the plan as claims administrator and as such shall perform the duties outlined in the *Preferred Provider Organization Network Program Agreement*. These duties include, but are not limited to the following:

1. Enrolling eligible employees and dependents in the plan upon notification of enrollment by the member organization through Everence;
2. Terminating the coverage of plan participants upon notification of termination by the member organization through Everence;
3. Issuing an identification card to each plan participant upon enrollment in the plan;
4. Administering the precertification, utilization management, and case management procedures of the plan according to Highmark's internal policies and procedures and in compliance with applicable law;
5. Processing and paying claims submitted to the plan in accordance with the terms of the plan, Highmark's administrative practices, and PPO network rules;
6. Preparing and issuing an *Explanation of Benefits* for claims submitted to the plan that have been processed by Highmark;
7. Hearing and deciding appeals of denied claims for plan benefits. If a plan participant requests review of the claims administrator's denial of a claim, the second level appeal will be facilitated by Everence and decided by the plan administrator;
8. Facilitating requests for external review of second level adverse benefit determinations with an independent review organization;
9. Maintaining current plan data;
10. Providing and/or certifying requested information necessary for filing reports; and
11. Seeking subrogation recoveries on behalf of the plan.

Highmark does not guarantee the payment of any benefits under the plan and does not assume any financial risk or obligation with respect to claims submitted to the plan.

E. Role of Everence Insurance Company

Everence Insurance Company (Everence) is not the insurer or the claims administrator of the plan. The plan has appointed Everence to act as exclusive agent on the plan's behalf in performing the plan's duties under the terms and provisions of the *Preferred Provider Organization Network Program Agreement*. The administrative duties of Everence are outlined in the *Administrative Services Agreement* between the plan and Everence and include the following:

1. Developing the summary plan description for the plan (which describes the terms and benefits of the plan) and other enrollment and cancellation forms required to administer the plan;
2. Preparing a *Summary of Benefits and Coverage* for each plan option, as required by the Patient Protection and Affordable Care Act of 2010 (ACA).
3. Providing notification to Highmark of the enrollment of new plan participants, upon timely notification by the member organization;
4. Provide notification to Highmark of the termination of coverage for plan participants, upon timely notification by the member organization;
5. Facilitating second level appeals of denied claims for benefits;
6. Billing, collecting, and forwarding to Highmark all reimbursements and administrative fees paid by member organizations;
7. Filing claims with insurance companies providing excess loss insurance coverage to the plan; and
8. Providing all written, verbal, and electronic communications between the plan and Highmark.

Everence Insurance Company does not guarantee the payment of any benefits under the plan and does not assume any financial risk or obligation with respect to claims submitted to the plan.

Part XVIII, Provision of Protected Health Information to Plan Sponsor and Plan Administrator

A. Disclosure of Protected Health Information (PHI) to Plan Sponsor

The plan will not disclose protected health information (PHI) to the plan sponsor.

B. Permitted and Required Uses and Disclosure of Protected Health Information (PHI)

Unless otherwise permitted by law, and subject to the conditions of disclosure outlined in *Section C* of this *Part XVIII* and obtaining written certification pursuant to *Section D* of this *Part XVIII*, the plan may disclose PHI or electronic PHI to the plan administrator, provided the plan administrator uses or discloses such PHI or electronic PHI only to perform plan administration functions which the plan administrator performs on behalf of the plan.

Plan administration functions do not include functions performed by the plan administrator in connection with any other benefit or benefit plan of the plan administrator or any employment-related actions or decisions. Enrollment and disenrollment functions performed by the plan administrator are performed on behalf of plan participants and beneficiaries and are not plan administration functions. Enrollment and disenrollment information held by the plan administrator is held in its capacity as an employer and is not PHI.

Notwithstanding the provisions of this plan to the contrary, in no event shall the plan administrator be permitted to use or disclose PHI or electronic PHI in a manner that is inconsistent with 45 CFR §164.504(f).

C. Conditions of Disclosure for Plan Administration Purposes

Protected Health Information (PHI)

The plan administrator agrees that with respect to any PHI disclosed to it by the plan (other than enrollment/disenrollment information, summary health information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508 which are not subject to these restrictions), the plan administrator shall:

1. Not use or further disclose the PHI other than as permitted or required by the plan or as required by law.
2. Ensure that any agents, including a subcontractor to whom it provides PHI received from the plan, agree to the same restrictions and conditions that apply to the plan administrator with respect to PHI.
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan administrator.
4. Report to the plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware.
5. Make available to a plan participant who requests access, the plan participant's PHI in accordance with 45 CFR §164.524.
6. Make available to a plan participant who requests an amendment, the plan participant's PHI and incorporate any amendments to the plan participant's PHI in accordance with 45 CFR §164.526.
7. Make available to a plan participant the information required to provide an accounting of disclosures in accordance with 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 Health and Human Services for purposes of determining compliance by the plan with 45 CFR §164.504(f).
9. If feasible, return or destroy all PHI received from the plan that the plan administrator still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
10. Ensure that the adequate separation between the plan and the plan administrator (i.e., the firewall) required by 45 CFR §164.504(f)(2)(iii) is established.

Electronic Protected Health Information (PHI)

The plan administrator further agrees that if it creates, receives, maintains, or transmits electronic PHI (other than enrollment/disenrollment information and summary health information and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) on behalf of the plan, the plan administrator will:

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 the adequate separation between the plan and the plan administrator (i.e., the firewall), required by 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 it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information.
4. Report to the plan any security incident with respect to electronic PHI of which it becomes aware.

D. Certification of Plan Administrator

The plan shall disclose PHI to the plan administrator only upon the receipt of a certification by the plan administrator that the plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the plan administrator agrees to the conditions of disclosure set forth in *Section C* of this *Part XVIII*.

E. Permitted Uses and Disclosure of Summary Health Information

The plan or a health insurance issuer with respect to the plan, may disclose summary health information to the plan administrator, provided the plan administrator requests such summary health information for the purpose of:

1. Obtaining premium bids from health plan providers for providing health insurance coverage under the plan; or
2. Modifying, amending, or terminating the plan.

F. Adequate Separation Between the Plan and the Plan Administrator

The plan administrator shall only allow the FMHG Compliance Officer and members of the FMHG Board of Directors to have access to PHI. No other employees or individuals shall have access to PHI.

Such individuals shall only have access to and use such PHI to the extent necessary to perform the administrative functions that the plan administrator performs for the plan. In the event that any such employee does not comply with the provisions of this *Part XVIII*, the individual shall be subject to disciplinary action by the plan administrator for non-compliance pursuant to the plan administrator's employee disciplinary and termination procedures.

The plan administrator will ensure that the provisions of this *Section F* are supported by reasonable and appropriate security measures to the extent the individuals designated above create, receive, maintain, or transmit electronic PHI on behalf of the plan.

G. Definitions

For purposes of this *Part XVIII*, the following terms shall have the meaning set forth below unless otherwise provided by the plan:

Electronic protected health information (electronic PHI) — Protected health information that is transmitted by or maintained in any electronic media.

Plan administrator — The plan administrator of the plan is the Friends Mutual Health Group.

Plan sponsor — The plan sponsor of the plan is the Friends Mutual Health Group.

Protected health information (PHI) — Information that is created or received by the plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. PHI includes information of persons living or deceased.

The following components of a member's information also are considered PHI: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/ license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

Summary health information — Information: a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the plan administrator has provided health benefits under a group health plan; and b) from which the information described at 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

Part XIX, Highmark Member Services Support

A. Member Service

If you need help with a claim or have a question about your benefits under this plan, you can call the toll-free Member Service number on the back of your ID card or log onto the Highmark Blue Shield website at www.highmarkblueshield.com. For TTY/TDD hearing impaired service, dial 711 and the toll-free Member Service number on the back of your ID card. A Highmark Blue Shield Member Service representative can also help you with any coverage inquiry. Representatives are trained to answer your questions quickly, politely, and accurately.

B. Blues On Call℠ – 24/7 Health Decision Support

Call 1-888-BLUE-428 (1-888-258-3428) to be connected to a specially trained wellness professional. You can talk to a Health Coach whenever you like, any time of the day, any day of the week.

Health Coaches are specially trained registered nurses, dietitians and respiratory therapists who can help you make more informed health care and self-care (when appropriate) decisions. They can assist with a health symptom assessment, provide health-related information, and discuss your treatment options. Please be assured that your discussions with your Health Coach are kept strictly confidential.

Help with Common Illnesses, Injuries and Questions

Health Coaches can address any health topic that concerns you:

- Everyday conditions, such as a rash, an earache or a sprain
- A recent diagnosis you've received
- A scheduled medical test
- Planned surgery or other medical procedure
- Questions to ask your doctor at your next appointment
- How to care for a child or elder

You don't have to be ill to talk to a Health Coach Call to learn about programs and other resources to help you manage:

- Stress
- Personal nutrition
- Weight management
- Physical activities
- Insomnia
- Depression

Help with Chronic Conditions

If you have diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease or coronary artery disease, you need to manage your condition every day in order to stay healthy and avoid hospital stays. That means keeping track of medications, tests, doctor appointments and your diet. Your Blues On Call Health Coach can help you work more closely with your doctor and get more involved in taking good care of yourself.

You can even establish a relationship with a specific Health Coach and schedule time to talk about your concerns and conditions.

C. myCare Navigator℠ – 24/7 Health Advocate Support

Getting the right care and finding the right doctor and wellness services for you and your family is now as quick and easy as calling myCare Navigator at 1-888-BLUE-428 (1-888-258-3428).

Your dedicated health advocate can help you and your family members:

1. Locate a primary care physician or get an appointment with a hard-to-reach specialist;
2. Get your medical records transferred;
3. Get a second opinion;
4. Understand your health care options;
5. Locate wellness resources, such as services for your special needs child or quality elder care for a parent; or
6. Handle billing questions and make the most of your care dollars.

Get the help you need to navigate the health care system easily and effectively. The same number that connects you to Blues On Call now connects you to your health advocate, myCare Navigator. Call 1-888-BLUE-428 (1-888-258-3428) for *total* care support.

D. Highmark Website

As a Highmark member, you have a wealth of health information at your fingertips. It's easy to access all your online offerings. Whether you are looking for a health care provider, managing your claims, want to make informed health care decisions on treatment options, or lead a healthier lifestyle, Highmark can help with online resources.

Go to www.highmarkblueshield.com. Then log in to your Member Home page to take advantage of resources available to help you understand your health status. Then, take steps toward real health improvement.

E. Baby BluePrints® Maternity Education and Support Program

If You Are Pregnant, Now is the Time to Enroll in Baby Blueprints

If you are expecting a baby, this is an exciting time for you. It's also a time when you have many questions and concerns about your and your developing baby's health.

To help you understand and manage every stage of pregnancy and childbirth, Highmark offers the Baby BluePrints Maternity Education and Support Program.

By enrolling in this free program, you will have access to online information on all aspects of pregnancy and childbirth. Baby BluePrints will also provide you with personal support from a nurse Health Coach available to you throughout your pregnancy.

Easy Enrollment

Just call toll-free at (866) 918-5267. You can enroll at any time during your pregnancy. We encourage you to enroll early in your pregnancy to take full advantage of this program.

F. Information for Non-English-Speaking Members

Non-English-speaking members have access to clear benefits information. They can call the toll-free Member Service number on their ID card to be connected to a language services interpreter line. Highmark Member Service representatives are trained to make the connection.

G. Registration Information

Highmark is a registered mark of Highmark, Inc.

Blues On Call and myCare Navigator are service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield companies.

Baby BluePrints, BlueCard, BlueShield, and the Shield symbol are registered service marks of the Blue Cross Blue Shield Association.

Blue Cross Blue Shield Global is a trademark of the Blue Cross Blue Shield Association.

The Blue Cross and Blue Shield Association is an independent company that does not provide Highmark Blue Cross and Blue Shield products and services.

Part XX, Other Important Points

A. Subrogation

Subrogation means the plan's right to reimbursement — for loss under this summary plan description — for amounts you or any covered person recover for the same loss from any person or organization. No person shall take or do anything to defeat the plan's rights of subrogation.

Subrogation applies to all claims, demands, actions, and rights of recovery you or any covered person may have against a third party or parties and the third party's insurers for a covered person's illness or injury. The plan's subrogation rights apply to your own or any covered person's uninsured motorist, underinsured motorist, or no-fault

automobile insurance coverage, too. You or any covered person must reimburse the plan on whatever amount of money is received.

If the plan pays any benefits for a covered person because of an injury or illness that was caused by a third party, then the plan will pay benefits on the condition and with the agreement and understanding that the covered person will reimburse the plan for the amount of benefits paid (including costs and legal or attorney's fees in recovering the money) from the amount you or any covered person recover from the third party.

The plan shall be reimbursed in full in first priority from any monies to the extent of any and all benefits paid by the plan. You will not be required to reimburse the plan for more than you or any covered person receive by way of settlement or recovery on a judgment. If you or any covered person recover less than the plan has paid, you will not have to pay any additional money out of your pocket. If you or any covered person recover more than the plan has paid, you will be entitled to keep the difference between what was recovered and what the plan has paid.

If you or any covered person have a claim against a third party for an illness or injury, do not sign any releases or other papers that may compromise the plan's right to reimbursement or subrogation. **Be sure to check with Highmark before any papers are signed.** Any covered person must not hinder the plan's attempts to recover or resolve the claim with the third party unless Highmark gives prior written consent. Because of payments the plan makes on behalf of plan participants, all plan participants have an obligation to cooperate fully with Highmark in their efforts to seek reimbursement from a third party.

B. No Contract of Employment

The plan does not constitute a contract of employment between you and your member organization. The rights of your member organization with regard to disciplinary action and termination of any employee, if necessary, are in no manner changed by your participation in the plan or any provision of it.

C. Overpayment

If for some reason the plan pays you more than you are entitled to, the plan has the right to subtract the overpayment from payments made to the provider on your behalf in the future.

D. Periodic Information Requests

In order to keep plan information up-to-date, Highmark may request basic information about you or your covered dependents that is required to pay claims according to plan provisions.

E. Assignment

The benefits provided by the plan are intended to provide for your family's health care needs. Therefore, you may not assign any of the benefits to which you may be entitled under the plan to any person or organization unless that person or organization has provided health care services to you or a covered member of your family.

F. Payment of Claims

The plan may require proof of payment before reimbursing you for claims that were not assigned to a health care provider.

If Highmark determines that a valid release cannot be given for payment of plan benefits, Highmark may, at its discretion, pay the individual who has assumed responsibility for your principal support and care. Because he or she has paid for your support and care, it is only fair for the plan to make payment to him or her.

If you should die before benefit payments have been made, Highmark may honor assignments you made before your death.

Any payment made by Highmark in accordance with this provision shall fully satisfy its liability for payment.

G. Misrepresentation

If you or your dependent intentionally misrepresent a material fact (either verbally or in writing) or commit fraud and because of that misrepresentation or fraud, coverage is given to an individual who would otherwise not be eligible for coverage, the plan has the right to rescind coverage from the date it became effective and pursue recovery of any benefits received. At least 30 days advance notice will be provided before plan coverage is rescinded.

Likewise, if a covered person knowingly makes a statement, either verbally or in writing, which is not true and because of that statement, a claim that would otherwise not be eligible for payment is paid, the plan has the right to pursue recovery of benefits received by the covered person as a result of the claim.

H. Clerical Error

Any clerical error by the plan administrator, an agent of the plan administrator, or a member organization in keeping records pertaining to plan coverage or delays in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment will be made when the error or delay is discovered.

In addition, any clerical error or delay by the plan administrator, an agent of the plan administrator, or a member organization in enrolling an individual as required by the terms of the plan will not invalidate coverage for which an individual would otherwise be eligible.

I. Enforceability

The plan (as described in this summary plan description and related documents which together constitute the plan) is maintained for the exclusive benefit of the employees of member organizations. As a participant in this plan, your rights to its coverage and any particular benefit that it provides are legally enforceable.

J. Amendment of the Plan

The plan administrator reserves the right to amend the plan at any time without prior notice to plan participants. Each member organization may change eligibility, enrollment, and contribution requirements for plan participation; and other designated provisions of the plan as negotiated with and approved by the plan administrator and Highmark. Any amendments to the plan will not be effective unless approved in writing by the plan administrator. Properly executed amendments shall be delivered to the plan and Highmark.

Plan participants will be notified of any amendment of the plan in writing.

K. Termination of the Plan

The plan administrator reserves the right to terminate the plan at any time, either in whole or in part, by an instrument properly executed and delivered to the plan and Highmark. Any such termination of the plan shall be made by resolution of the plan administrator. Plan participants will be notified of any termination of the plan in writing.

In the event the plan is terminated altogether, plan liability for payment of claims shall be limited to payment of those claims incurred as of the date the plan is terminated. Neither the plan, the plan sponsor, the plan administrator, nor the member organizations shall have any liability for charges, fees, or expenses that are incurred after the effective date of the termination of the plan.

L. Employer Participation

Participation under the plan is a choice made by individual employers (member organizations) and is made in agreement with the Friends Mutual Health Group as evidenced by the Cooperative Services Agreement. Your member organization may cancel its participation in the plan upon providing 90 days advance written notice to the Friends Mutual Health Group. The member organization’s decision to terminate its participation in the plan is without regard to the two preceding provisions in this section.

Part XXI, Miscellaneous Plan Information

Name of the Plan:
Friends Mutual Health Group Plan

Type of Benefit Plan:
Group Health Plan

Member Organization:
Foxdale Village
500 E. Marylyn Avenue
State College, PA 16801
(814) 272-2118

Plan Representative:
Julie Hartley

Plan Sponsor and Plan Administrator:
Friends Mutual Health Group
960 E. Main Street
Mount Joy, PA 17552
(877) 318-7319

EIN:
20-5892892

Type of Plan Administrator:
Contract Administrator

Agent for Service of Legal Process:
Plan Administrator

Claims Administrator:
Highmark Blue Shield
P.O. Box 1210
Pittsburgh, PA 15230-1210
(800) 226-2239

Plan Agent:
Everence Insurance Company
P.O. Box 483
Goshen, IN 46527
(574) 533-9511 or (800) 348-7468

Plan Number:
501

Plan Year:
Jan. 1 – Dec. 31

Plan Effective Date:
March 1, 2007

Plan Revision Date:
Jan. 1, 2021

Plan participants may contact Human Resources to obtain premium contribution rates for plan coverage.

Plan participants who are on continuation of coverage (see *Part XV*) must pay the entire cost of their coverage.

Plan participants who are on any leave of employment that qualifies under the Family and Medical Leave Act of 1993 must pay the same level of premium contributions they were paying as an active employee.

Plan participants who extend plan coverage while on military leave (see *Part III, Section A*), must pay the same level of premium contribution they were paying as an active employee if the period of military service is 30 days or less. For periods of military service that exceed 30 days, the plan participant must pay the entire cost of coverage.

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Outpatient Prescription Drug Rider

This rider is attached to and becomes a part of the Summary Plan Description for the Friends Mutual Health Group Plan. It outlines the outpatient prescription drug coverage provided under the plan. This rider replaces *Outpatient Prescription Drug Rider* #2195192, effective Jan. 1, 2021.

Your outpatient prescription drug coverage is administered through CVS Caremark. The plan only covers drugs available to the public with a prescription written by a physician, dentist, or practitioner licensed to do so, identified by a prescription number, and dispensed by a licensed pharmacist.

Coverage under the plan includes prescription drugs and medicines prescribed by a licensed physician in connection with the treatment of an illness or injury covered by the plan. This coverage includes fertility drugs (covered up to a lifetime maximum of $3,000 per covered person), insulin, blood glucose monitors, insulin infusion devices, insulin syringes, glucose test strips, and lancets*.

*Blood glucose monitors, insulin infusion devices, insulin syringes, blood glucose and urine test strips, and lancets are also covered under the diabetes treatment benefit outlined in *Part IX, Section G*.

Coverage does not include:
1. Over-the-counter drugs;
2. Drugs that can be purchased without a prescription;
3. Drugs used to terminate a pregnancy;
4. Drugs that are considered experimental or investigative; and
5. Drugs not approved by the U.S. Food and Drug Administration for sale in the U.S.

Preventive drug measures prescribed by a physician; and oral contraceptive drugs, transdermal contraceptive patches, and contraceptive devices available only by prescription that are required to be covered by the Patient Protection and Affordable Care Act of 2010 (PPACA) are covered under the Adult Preventive Care Services provision outlined in *Part IX, Section Q* of the base summary plan description.

Your outpatient prescription drug coverage is subject to the provisions and limitations outlined in the base summary plan description. If you have questions about your outpatient prescription drug coverage, please contact Everence Member Services at (800) 348-7468 or (574) 533-9511.

Prescription Drug Card

You have been given a prescription drug card which allows you to purchase prescription drugs at preferred prices. To take advantage of this arrangement, you must purchase prescription drugs with your prescription drug card at participating pharmacies. You can find the nearest participating pharmacy on CVS Caremark's website, www.caremark.com. **The plan will not pay for any prescription drugs when purchased without the prescription drug card or at a non-participating pharmacy.** When you purchase prescription drugs using your prescription drug card under this plan, benefits are not coordinated with other prescription drug coverage you may have.

You may also purchase prescription drugs by mail through the CVS Caremark Mail Service Program. To sign up for this service you must complete and mail an order form to CVS Caremark at the address on the order form for your first prescription. Refills can then be ordered by calling CVS Caremark at (800) 966-5772 or following the instructions on CVS Caremark's website, www.caremark.com.

When you use your prescription drug card to purchase prescription drugs, you do not need to file a claim to receive benefits.

Compound Prescription Drugs

The plan will not cover compound prescription drugs that cost less than $300 and include an ingredient not approved by the U.S. Food and Drug Administration.

In addition, compound prescription drugs costing $300 or more require preauthorization through CVS Caremark to ensure the medical necessity and appropriateness of the prescription.

You or your physician may call CVS Caremark at (800) 294-5979 to determine if a specific compound drug costs $300 or more and requires preauthorization prior to purchase at a participating pharmacy or through mail order. If a compound prescription drug requires preauthorization, your physician must obtain authorization through CVS Caremark at (800)

294-5979 prior to the dispensing of the drug. If the compound prescription drug is determined by CVS Caremark to be medically necessary and appropriate, the drug will be covered by the plan.

If you purchase a compound prescription drug that is not covered by the plan or if you do not obtain prior approval for a compound drug costing $300 or more through CVS Caremark, there are no plan benefits and you will be responsible for the total cost of the drug.

Prescription Drugs Costing $5,000 or More

All prescription drugs costing $5,000 or more require preauthorization through Everence Insurance Company to ensure the medical necessity and appropriateness of the drug. This requirement does not apply to specialty pharmaceuticals which are required to be approved through CVS Caremark as outlined below regardless of the cost.

You or your physician may call Everence Insurance Company at (800) 348-7468 to determine if a specific prescription drug costs $5,000 or more and requires preauthorization prior to purchase at a participating pharmacy or through mail order. If a prescription drug requires preauthorization, your physician must obtain authorization from Everence at (800) 348-7468 prior to the dispensing of the drug. If the prescription drug is determined by Everence to be medically necessary and appropriate, the drug will be covered by the plan.

If you do not obtain prior approval for a prescription drug costing $5,000 or more through Everence or if the drug is not covered by the plan, there are no plan benefits and you will be responsible for the total cost of the drug.

Cost Sharing

When you buy prescription drugs, you are responsible for a portion of the cost (called a copayment) for each prescription at the time of purchase. The amount of your copayment is based on the category of drug you purchase as listed below:

	Category of drug	Your copay[1]
Tier 1	Generic drugs[2]: • Participating retail pharmacy • CVS retail pharmacy • Caremark mail service program	 • 10%, up to a 30-day maximum supply • 10%, 90-day supply • 10%, up to a 90-day maximum supply
Tier 2	Preferred brand-name drugs on the Preferred Drug List[3]: • Participating retail pharmacy • CVS retail pharmacy • Caremark mail service program	 • 30%, up to a 30-day maximum supply • 30%, 90-day supply • 30%, up to a 90-day maximum supply
Tier 3	All other brand-name drugs[3]: • Participating retail pharmacy • CVS retail pharmacy • Caremark mail service program	 • 50%, up to a 30-day maximum supply • 50%, 90-day supply • 50%, up to a 90-day maximum supply
Tier 4	Specialty pharmaceuticals purchased from a Caremark specialty pharmacy as directed by CVS Caremark[4]	30%, up to a 30-day maximum supply

[1]Copays for prescription drugs are not counted toward meeting your calendar-year deductible and coinsurance requirements but are counted toward the total annual out-of-pocket maximum.

[2]Select generic statin drugs for prevention of cardiovascular disease are covered under the Adult Preventive Care Services provision (see *Part IX, Section Q*).

[3]Generic drugs are mandatory when available. If you purchase a brand-name drug when a generic equivalent drug is available, you will have to pay the copay for generic drugs plus the difference in cost between the generic and brand-name drug, unless your physician has indicated a need for the brand-name drug on the prescription. The difference in cost is applied to the total annual out-of-pocket maximum.

[4]Fertility drugs are covered up to a lifetime maximum of $3,000 for each covered person. The covered amount which is applied to the lifetime maximum is the total cost of the drug, including both your copay **and** the remaining amount paid by the plan.

Specialty Pharmaceuticals

Specialty pharmaceuticals include oral, injectable, and infused medications that are biopharmaceuticals (bioengineered proteins), blood-derived products, and complex molecules. In general, specialty pharmaceuticals included in Tier 4 include, but are not limited to blood modifiers and drugs prescribed for the treatment of respiratory syncytial virus (RSV), growth hormone deficiency, Crohn's disease, hepatitis C, hemophilia, Gaucher's disease, cystic fibrosis, multiple sclerosis, rheumatoid arthritis, asthma, enzyme replacement, immune deficiencies, pulmonary arterial hypertension, and other chronic low prevalence diseases.

You may call Everence Member Services at (800) 348-7468 or (574) 533-9511 to determine if the specialty pharmaceuticals you or your covered dependent need are included in Tier 4.

You or your physician must obtain approval for all specialty pharmaceuticals through CVS Caremark at (800) 237-2767 before treatment initially begins and the drugs are purchased. You must purchase specialty pharmaceuticals from a Caremark specialty pharmacy, as directed by CVS Caremark, in order for the drugs to be covered by the plan.

If you do not obtain prior approval for specialty pharmaceuticals through CVS Caremark or if you do not purchase the drugs from a Caremark specialty pharmacy as directed by CVS Caremark, there are no plan benefits and you will be responsible for the total cost of the drugs.

Generic and Brand-name Drugs

The generic name of a drug is its chemical name. The brand name is the trade name under which a drug may be advertised and sold. By law, generic and brand-name drugs must meet the same standards for safety, strength, and effectiveness.

Preferred Drug List

The Preferred Drug List is a specific list of prescription drugs selected by health care experts based on a drug's clinical and cost effectiveness. The list is provided to you after you are enrolled in the plan. Additional copies are available upon request. The Preferred Drug List is intended to be given to your physician so he or she can decide which category of prescription drug is best suited to your situation.

75 percent of a prescription must be used before refill is allowed for all prescription drugs other than specialty pharmaceuticals, 80 percent of the prescription for specialty pharmaceuticals.

Amendment to the Friends Mutual Health Group Plan for Foxdale Village

This Amendment is attached to and becomes a part of the Summary Plan Description for the Friends Mutual Health Group Plan for Foxdale Village. It outlines changes to the plan, effective January 1, 2013.

Eligibility for plan coverage for an employee's spouse or domestic partner is changed as follows:

A covered employee's spouse or domestic partner is not eligible to be covered by the plan if the spouse or domestic partner is eligible for group health plan coverage through his or her employer and the employer pays any portion of the premium cost.

The employee must notify the plan representative if the employee's covered spouse or domestic partner becomes eligible to enroll in a group health plan provided by his or her employer and the employer pays any portion of the premium cost.

Termination of plan coverage for an employee's covered spouse or domestic partner is changed as follows:

Plan coverage for an employee's covered spouse or domestic partner will end the day the covered spouse or domestic partner becomes eligible for group health plan coverage through his or her employer and the employer pays any portion of the premium cost.

Except as specifically modified or revised in this Amendment, all provisions and terms of the Summary Plan Description for the Friends Mutual Health Group Plan for Foxdale Village, including any previous modifications, shall remain unchanged.

Policy and Procedure

Eligibility for Health Coverage under the Affordable Care Act

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Policy:

This policy is part of, and incorporated by reference into the Friends Mutual Health Group Plan ("Health Plan") and sets forth the methods by which Foxdale Village will determine whether an Employee is Full-Time under Internal Revenue Code ("Code") § 4980H for purposes of:

1. meeting the Employer's reporting obligations under Code § 6056; and
2. determining a category of eligibility under the Health Plan that is established and maintained by Foxdale Village.

An Employee who is determined by Foxdale Village to be a Full-Time Employee during a Measurement Period shall be reported as a Full-Time Employee during the corresponding Stability Period for the applicable periods under Code § 6056. Unless otherwise excluded under the terms of the Health Plan, such Full-Time Employee will also have an opportunity to elect, change, or decline Health Plan coverage for himself or herself and his or her dependents during the related Administrative Period, with any elected coverage effective the first day of the related Stability Period.

This Policy is intended to satisfy the rules under Treasury Regulation § 54.4980H-3, will be interpreted consistently therewith, and will be revised to conform to changes that may be made by any subsequent guidance.

Procedure:

1. DEFINITIONS:

   a. Administrative Period – The period immediately following a Measurement Period during which the Employer identifies which Employees are Full-Time Employees and opens enrollment under the Health Plan.

      i. For new Part-Time, Casual or Seasonal employees the initial Administrative Period is the one-month period immediately following the employee's initial Measurement Period. Thereafter, such employee will have the same Administrative Period as an Ongoing Employee.

      ii. For Ongoing Employees, the Administrative Period is the period that begins the first day that immediately follows the standard Measurement period and ends on December 31.

   b. Casual Employee – An Employee for whom, based on the facts and circumstances at the Employee's hire date, Foxdale Village cannot determine whether the Employee is reasonably expected to be employed on average at least 30 Hours of Service per week during the initial Measurement Period because the Employee's hours are variable or otherwise uncertain.

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c. Eligible Employees – Employees who are designated as Full-Time at hire or employees who are determined to be Full-Time according to this policy.

d. Employee – A common law employee of the Employer.

e. Full-Time Employee – An Employee who is employed an average of at least 30 Hours of service per week, as determined under this Policy.

f. Health Plan – A group health plan that provides minimum essential coverage, as defined in Code § 5000A(f), which is established and maintained by Foxdale Village, and amended from time to time.

g. Hour of Service – each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer; and each hour for which an Employee is paid, or entitled to payment by Foxdale Village for a period of time during which no duties are performed, due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence (as defined in 29 CFR 2530.200b-2(a).

   i. Notwithstanding the preceding, an Hour of Service shall not include any hour for services performed as a bona fide volunteer;

h. Measurement Period – The period used by the Employer to determine whether an Employee is a Full-Time Employee.

   i. For a newly hired Part-Time, Casual or Seasonal Employee, the initial Measurement Period is the Employee's initial 12 months of employment with Foxdale Village beginning with the first day of the month following the date of hire.

   ii. For Ongoing Employees, the standard Measurement Period is the 12-month period that begins the first day of the pay period that includes November 1 and ends on the last day of the pay period immediately preceding November 1 of the next year.

i. Ongoing Employee – An Employee who has been employed by Foxdale Village for at least one complete standard Measurement Period.

j. Part-Time Employee – A new Employee reasonably expected to be employed on average less than 30 Hours of Service per week during the initial Measurement Period, based on the facts and circumstances at the Employee's start date.

k. Seasonal Employee – An Employee who is hired into a position for which the customary annual employment is six months or less. Customary annual employment means that by the nature of the position, an Employee in this position typically works for a period of six months or less, and

that period begins each calendar year in approximately the same part of the year, such as summer or winter.

l. Special Unpaid Leave – Unpaid leave under the Family and Medical Leave Act, unpaid leave subject to the Uniformed Services Employment and Reemployment Rights Act, and unpaid leave due to jury duty.

m. Stability Period – The period that follows, and is associated with, a Measurement Period (and related Administrative Period) during which an Employee's status as a Full-Time Employee (or not as a Full-Time Employee, as the case may be) will generally be locked in place.

   i. For a new Part-Time, Casual or Seasonal Employee the initial Stability Period is the 12-month period following the Employee's initial Measurement Period and related Administrative Period. Thereafter, such Employee will have the same Stability Period as an Ongoing Employee.

   ii. For Ongoing Employees, the Stability Period is the 12-month period following the standard Measurement Period and related Administrative Period that begins January 1 and ends December 31. The first stability period shall begin January 1, 2015 and end December 31, 2015.

2. PROCEDURES FOR COUNTING AND CREDITING HOURS OF SERVICE:

   a. Hourly Employees – Foxdale Village will calculate actual hours of service from records of hours worked and hours for which payment is made or due for all employees who are paid by Foxdale Village on an hourly basis.

   b. Salaried Employees – Foxdale village will calculate actual hours of service from records of hours worked and hours for which payment is made or due for all employees who are paid by Foxdale Villager on a salaried basis.

   c. Ongoing Employees - an Ongoing Employee is a Full-Time employee for a Stability Period if, during the preceding standard Measurement Period, the Ongoing Employee worked an average of at least 30 hours of service per week. Unless otherwise excluded under the terms of the Health Plan, such Full-Time employee will have an opportunity to elect, change, or decline Health Plan coverage for himself or herself and his or her dependents during the related Administrative Period, with any elected coverage effective the first day of the related Stability Period.

      i. An Ongoing Employee who does not work an average of at least 30 hours of service per week over a standard Measurement Period is not a Full-Time employee for the

subsequent Stability Period. Notwithstanding the preceding, if an Employee described in this paragraph experiences a change in employment status during the subsequent Stability Period such that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected to be a Full-Time Employee, then such Employee will be treated as a Full-Time Employee as of the first day of the next calendar month following the change in employment status and shall have an opportunity to elect or decline Health Plan coverage for himself or herself and his or her dependents during the 30-day enrollment period that begins the first day of the month following the change in employment status. Any elected coverage will be effective the first day of the month following the change in employment status.

ii. Notwithstanding the previous paragraph, the rule in this paragraph applies to an Ongoing Employee who has been continuously offered coverage under the Health Plan since no later than the first day of employment and who experiences a change in employment status during a Stability Period such that if the Employee had begun employment in the new position, the Employee would have reasonably been expected not to be employed on average at least 30 Hours of Service per week. Such Employee will not be treated as a Full-Time Employee beginning on the first day of the fourth full calendar month following the change in employment status, provided that the Employee actually averages less than 30 Hours of Service per week for each of the three full calendar months following the change in employment status. The determination of Full-Time Employee status for such Employee shall be made on a monthly basis until the end of the first full Measurement Period (and related Administrative Period) that is completed after the change in employment status occurs.

iii. If an Ongoing Employee goes on a paid or unpaid leave of absence from Foxdale Village the Employee will continue to be a Full-Time Employee or not a Full-Time Employee, as applicable, for the remainder of the Stability Period in which the leave begins. Thereafter, the Employee's status as a Full-Time Employee or not a Full-Time Employee for the subsequent Stability Period will be determined based on Hours of Service during the preceding Measurement Period, taking into account any Special Unpaid Leave. The treatment of such Ongoing Employee as a new Employee or a continuing Employee upon resumption of services shall be determined under the rehire rules defined later in this Policy.

d. New Full-Time Employees - A new Employee who is reasonably expected at the Employee's start date to be a Full-Time Employee (and who is not a Seasonal Employee), and as long as the Employee is classified as Full-Time, will retain eligibility until the end of the first full <u>standard</u> Measurement Period after hire, at which time he or she will be tested under that standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees. Health Plan coverage will begin on the first day of the month following the

Employee's start date as long as the Employee enrolls within the 30-day enrollment period that follows the Employee's start date.

i. If a new Employee described in this section experiences a change in employment status before the Employee has been employed for an entire standard Measurement Period, such that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected not to be employed on average at least 30 Hours of Service per week, then, beginning on the first day of the next calendar month following the change in employment status, the determination of Full-Time Employee status for such Employee shall be made on a monthly basis until such time that the new Employee has been employed for an entire standard Measurement Period, at which time he or she will be tested under that standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees.

ii. If a new Employee described in this section goes on a paid or unpaid leave of absence from Foxdale Village before the Employee has been employed for an entire standard Measurement Period, then beginning on the first day of the next calendar month following the date the leave of absence begins, the determination of Full-Time Employee status for such Employee shall be made on a monthly basis until such time that the new Employee has been employed for an entire standard Measurement Period, at which time he or she will be tested under that standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees. Notwithstanding a determination that an Employee is not a Full-Time Employee with respect to a calendar month in which he or she is on a leave of absence, Health Plan coverage shall continue to the extent required under the FMLA or USERRA, or as elected under the continuation of coverage provision.

e. New Part-Time, Casual and Seasonal Employees will be tested under an initial Measurement Period to determine whether they are Full-Time Employees.

i. A new Part-Time, Casual or Seasonal Employee who is employed by Foxdale Village an average of at least 30 Hours of Service per week over his or her initial Measurement Period will be a Full-Time Employee for his or her initial Stability Period. Unless otherwise excluded by the terms of the Health Plan, such Employee will have an opportunity to elect Health Plan coverage for himself or herself and his or her dependents during the related initial Administrative Period.

ii. A new Part-Time, Casual and Seasonal Employee who is not employed by Foxdale Village an average of at least 30 Hours of Service per week over his or her initial Measurement Period will not be a Full-Time Employee for his or her initial Stability Period. Notwithstanding the preceding, if a new Part-time, Casual or Seasonal Employee experiences a change in employment status during his or her initial Stability Period such

that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected to be a Full-Time Employee, then such Employee will be treated as a Full-Time Employee as of the first day of the next calendar month following the change in employment status and shall have an opportunity to elect or decline Health Plan coverage for himself or herself and his or her dependents during the 30-day enrollment period that begins the first day of the month following the change in employment status. Any elected coverage will be effective the first day of the month following the change in employment status.

iii. At such time that a new Part-Time, Casual or Seasonal Employee has been employed for an entire standard Measurement Period, he or she will be tested under that standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees; provided, however, that a new Part-Time, Casual or Seasonal Employee who is determined to be a Full-Time Employee for his or her initial Stability Period will continue to be a Full-Time Employee through the end of that initial Stability Period, even if he or she is not determined to be a Full-Time Employee during the standard Measurement Period.

iv. If a new Part-Time, Casual or Seasonal Employee is reclassified into a Full-Time position before the end of the initial Measurement Period, and reasonably expected to average more than 30 hours per week, the Employer will treat the Employee as a Full-Time Employee on the first day of the month following the change in employment status. As long as the Employee enrolls within the 30-day enrollment period that follows the change in employment status to Full-Time, Health Plan coverage for the Employee and his or her dependents will begin the <u>first</u> day of the month following change in employment status to Full-Time.

f. Factors for Determining Employee Status – For purposes of determining whether an Employee is reasonably expected at his or her start date to be a Full-Time Employee, who is not Part-Time, Casual or Seasonal Employee, Foxdale Village will consider all of the facts and circumstances, including the following factors:

i. the classification of the Employee who vacated the position;

ii. the extent to which Hours of Service of Ongoing Employees in the same or comparable positions have varied above and below an average of 30 Hours of Service per week during recent Measurement Periods; and

iii. how the position was advertised, or otherwise communicated to the new Employee or otherwise documented (for example, through a job description), in describing the Hours of Service required;

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iv. No single factor is determinative. In determining an Employee's status, the Employer will not take into account the likelihood that the Employee may terminate employment with the Employer before the end of an initial Measurement Period in determining expectation of future Hours of Service.

g. Use of Payroll Periods – Foxdale Village will treat as a Measurement Period a period that:

i. begins on the first day of the bi-weekly payroll period that includes the first day of the Measurement Period, and

ii. ends on the last day of the bi-weekly payroll period that immediately precedes the last day of the Measurement Period.

iii. By way of example, for Ongoing Employees who are paid on a bi-weekly basis, the first standard Measurement Period that runs from November 1, 2014, through October 31, 2015 will actually be measured by the period that begins on October 26, 2014 (the first day of the payroll period that includes November 1) and ends on October 24, 2015 (the last day of the payroll period immediately preceding October 31).

iv. When determining an Employee's average Hours of Service for a Measurement Period, any hours related to Special Unpaid Leave will be excluded. An Employee who is not credited with an Hour of Service for a period of 13 consecutive weeks will be treated as a new Employee upon any resumption of their services for Foxdale Village under this Policy.

3. ADMINISTRATION, REVIEW AND AMENDMENT OF POLICY:

a. Foxdale Village will administer Measurement Periods for new and Ongoing Employees, determine an Employee's status as a Full-Time Employee (or not a Full-Time Employee, as the case may be) during Administrative Periods, and provide coverage under the Health Plan during Stability Periods to Eligible Employees determined to be Full-Time Employees, all in accordance with this Policy and the terms of the Health Plan. Foxdale Village has full and absolute discretionary authority to interpret the terms of this Policy to determine whether its Eligible Employees are Full-Time Employees under the Health Plan. Employees who have questions regarding this Policy may contact the Director of Human Resources for more information.

b. Foxdale Village will periodically review this Policy for compliance under applicable regulations and other guidance. Foxdale Village has the right, in its sole and absolute discretion, to revise this Policy at any time to ensure legal compliance and to further the goals of Foxdale Village.