Medical Plan
Summary Plan Description (SPD)
for

Valley-Wide Health Systems, Inc.

Amended & Restated **August 1, 2019**

SPD Table of Contents

For assistance in a non-English language, please call 1-877-241-6310.
Para obtener asistencia en Español, por favor llame al número arriba.

Introduction

Welcome to the Valley-Wide Health Systems, Inc. Medical Plan.

This document explains the operation of your health plan. Please call **1-877-241-6310** if you have any questions.

Introduction
The Plan Sponsor has established the Plan, for the benefit of Employees, to help offset the financial impact of an Injury or Sickness. This is the final version of your benefits.

The Plan Document describes the terms for payment of covered medical and prescription charges.

Applicable Law
This is a self-funded benefit plan under the Employee Retirement Income Security Act of 1974 ("ERISA"). Federal law preempts State law.

Discretionary Authority
HealthEZ will have sole and final discretionary authority to interpret all Plan provisions. The Plan Sponsor reserves the right to amend any part of the plan or terminate the Plan at any time.

Type of Administration
The Plan is a self-funded group health plan and the plan administration is provided by HealthEZ.

Fiduciary
The Plan Sponsor is the fiduciary. HealthEZ is not a fiduciary of the Plan.

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with HealthEZ. You must exercise your appeal rights before bringing legal action.

Plan Contributions & Funding
The Plan is funded by the Plan Sponsor and covered Employees. The Plan Sponsor determines the level of Employee contributions. The Plan is insured by a reinsurance carrier.

Eligibility

Eligibility Requirements are determined by your employer**.** If you have any questions regarding eligibility, review your Employee handbook and/or call your employer.

REQUIREMENTS	
Employee	Full Time Employees: 30 hours per week Doctors: 20 hours per week
Waiting Period	First of the month following date of hire
Eligible Dependent	1. An Employee's lawfully married spouse; 2. An Employee's common-law spouse; 3. An Employee's Domestic Partner; 4. An Employee's Child who is less than 26 years of age; and 5. An Employee's Child, regardless of age, who was continuously covered before reaching the age of 26, who is mentally or physically incapable of sustaining his or her own living. The Plan reserves the right to require documentation to establish a Dependent relationship.
Coverage Termination	Last day of the month once no longer eligible.
Rehired Employees	If an Employee is rehired within 13 weeks of their termination, they are eligible no later than first of the month following that rehire.

Enrollment. An Employee must enroll for coverage with the Plan Sponsor within 31 days after the Employee becomes eligible. This enrollment cannot be dropped without a qualifying event. During Open Enrollment, Employees will be able to elect, change, or discontinue coverage. The Plan Sponsor must forward the completed enrollment to HealthEZ in a timely manner.

SPECIAL ENROLLMENT RIGHTS

Federal law allows a Special Enrollment Period if you had a qualifying event. This request for enrollment must be made within 31 days of the qualifying event. Coverage will be effective on the date of the qualifying event and an Employee who is already enrolled in one plan may make changes to their enrollment.

Qualifying events include:

- Loss of health coverage
    - Losing existing health coverage, including job-based, individual, and student plans

- Losing eligibility for Medicare, Medicaid, or CHIP
    - If an Employee has declined enrollment in the Plan for themselves or dependents because of coverage under Medicaid or the CHIPRA, there may be a right to enroll in this Plan if there is a loss of the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.
- Turning 26 and losing coverage through a parent's plan

- Changes in household
    - Getting married or divorced
    - Having a baby or adopting a child
    - Death in the family

Note: If other health plan coverage was lost because of failure to pay coverage premiums or required contributions, that individual does not have a Special Enrollment Period right.

TERMINATION OF COVERAGE

The Plan Sponsor or HealthEZ have the right to rescind any coverage for cause, including making a fraudulent claim or lying when obtaining coverage. The Employee or Dependent will be responsible for all claims paid on their behalf.

Coverage Termination

Coverage will terminate on the earliest of these dates:

- The date the Plan is terminated;
- The last day of the month the Employee ceases to be Eligible.

Coverage during Disability or Leave of Absence

A person may remain eligible for a limited time if disabled or during a leave of absence. Refer to your Employee handbook for further information. If coverage continuance is granted, coverage will end at the earliest of these dates:

- The employer ends the continuance or
- Maximum period available under FMLA and/or COBRA.

Employees on Military Leave (USERRA). For Employees who continue coverage while in military service, coverage will terminate at the earliest of these dates:

- The 24-month period beginning on the date absence begins; or
- The date the Employee fails to return to work as required

A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, unless on active duty for 30 days or less.

A Waiting Period may not be imposed upon reemployment if one would not have been imposed had coverage not been terminated because of military service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of active military service.

The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. Dependents do not have any independent right to elect USERRA health plan continuation

Schedule of Benefits

Call 1-877-241-6310 to verify eligibility for benefits before the charge is Incurred.

Reimbursement from the Plan may be reduced or denied due to the provisions in the Plan, such as coordination of benefits, subrogation, or medical necessity.

DEDUCTIBLE

Before benefits can be paid in a Plan Year, a Plan Participant must pay the Deductible shown in the Schedule of Benefits.

OUT-OF-POCKET MAXIMUM

After the deductible is met, a Plan Participant will be required to continue to pay for a share of the Covered Expenses until the out-of-pocket maximum is met. Once the out-of-pocket maximum is reached, the Plan will pay for the entirety of the Covered Expenses.

For those Employees who have elected family coverage:

The health plan(s) offered has an embedded Deductible. This means that each individual will **only** have to meet the individual Deductible before the Plan begins paying benefits.

The health plan(s) offered has an embedded out-of-pocket maximum. This means that each individual will **only** have to meet the individual out-of-pocket maximum before the Plan begins paying in full.

COPAY AND COINSURANCE

Copay. A flat fee that is paid each time a service is provided.

Coinsurance. A portion of the cost of the service that the Plan Participant pays after the deductible is met.

Copayments and coinsurance accrue toward the out-of-pocket maximum, but not toward the deductible.

PROVIDER NETWORK

Your provider network is displayed on the front of your ID card.

This Plan has entered into an agreement with provider networks. In-network Providers have agreed to charge reduced fees to Plan Participants.

The Plan may pay for out-of-network services at the in-network benefit level if:

- A Plan Participant has no in-Network Providers in the necessary specialty within the PPO service area; or
- A Plan Participant unavoidably receives services from an out-of-network Provider at an in-Network facility.

Additional information about this option, as well as a list of in-network Providers, will be made available to a Plan Participant as needed.

INFORMATION AND RECORDS

HealthEZ may require additional information to make a benefit determination. The Plan Participant or Provider must send this information in the timeframe requested. Failure to send will result in denial of payment.

CLAIMS REVIEW

HealthEZ may use its discretionary authority to utilize an independent bill review and/or claim audit program.

HealthEZ has the discretionary authority to reduce any charge to a Usual and Customary or Reasonable amount. The Medicare reimbursement methodology is used in determining a Usual and Customary or Reasonable amount by the Plan.

Schedule of Benefits
COPAY PLAN

Embedded Deductible Embedded Out-of-Pocket Maximum	In Network	Out of Network
DEDUCTIBLE		
Individual Coverage	$1,000	$10,000
Family Coverage	$2,000	$20,000
Deductible accumulates towards out of pocket maximum.		
OUT-OF-POCKET MAXIMUM		
Individual Coverage	$5,000	$20,000
Family Coverage	$10,000	$40,000
Both Medical and Pharmacy copayments will accrue toward the out-of-pocket maximum		

Deductible Year	Grandfathered status	Coinsurance/Copay
August 1st to July 31st	Not grandfathered	Indicates Plan Participant responsibility.

PREVENTIVE CARE SERVICES		
Well Child Care (up to age 18)	No Charge	50% Coinsurance After Deductible
Adult Preventive Care	No Charge	50% Coinsurance After Deductible
Routine Prenatal care.	No Charge	50% Coinsurance After Deductible
Breast Feeding Equipment Limit to one pump per pregnancy with a $250 limit for reimbursement.	No Charge	No Charge
Routine Eye Exam One per 12 months	No Charge	50% Coinsurance After Deductible

CLINIC CHARGES		
Physician Office Visit Includes office visits and associated labs & x-rays	$20 Copay	50% Coinsurance After Deductible
Specialist Office Visit	$40 Copay	50% Coinsurance After Deductible
Urgent Care Clinic	$50 Copay	$50 Copay
Allergy Shots	PCP: $20 Copay Specialty: $40 Copay	50% Coinsurance After Deductible
Immunizations-Foreign Travel	10% Coinsurance After Deductible	50% Coinsurance After Deductible
Temporomandibular Joint Disorder (TMJ) No Hardware coverage	10% Coinsurance After Deductible	50% Coinsurance After Deductible
Infertility Care, services, supplies for the diagnosis and charges for surgical correction of physical abnormalities. No coverage for assisted reproduction.	10% Coinsurance After Deductible	50% Coinsurance After Deductible
Infusions and Injections May require precertification.	10% Coinsurance After Deductible	50% Coinsurance After Deductible
LABS AND SCANS		
Outpatient Lab, Pathology, X-Ray	Labs: $30 Copay X-Rays: $55 Copay	50% Coinsurance After Deductible
Complex Imaging: MRI/CT/PET Scans May require precertification.	10% Coinsurance After Deductible	50% Coinsurance After Deductible
HOSPITAL CHARGES		
Inpatient Hospital Services Requires precertification.	10% Coinsurance After Deductible	50% Coinsurance After Deductible
Outpatient Procedures May require precertification.	10% Coinsurance After Deductible	50% Coinsurance After Deductible
Organ Transplants Must be performed at a Designated Center of Excellence for Transplants. Requires precertification.	10% Coinsurance After Deductible	Not Covered
Emergency Room Care	$200 Copay	$200 Copay
Ambulance Ground Ambulance Cap of $5,000 per event. Air Ambulance Cap of $15,000 per event.	10% Coinsurance After Deductible	10% Coinsurance After Deductible

Bariatric Surgery $100,000 lifetime limit See *Covered Medical Expenses* section for further limitations	10% Coinsurance After Deductible	50% Coinsurance After Deductible
Skilled Nursing Facility Requires precertification. 60 days per year maximum.	10% Coinsurance After Deductible	50% Coinsurance After Deductible
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES		
Inpatient, Residential, Partial Hospitalization, or Intensive Outpatient Requires precertification	10% Coinsurance After Deductible	50% Coinsurance After Deductible
Office Visit	$20 Copay	50% Coinsurance After Deductible
REHABILITATIVE/ HABILITATIVE OUTPATIENT THERAPY		
Behavioral, Occupational, and Speech Therapy Requires precertification. 20 visit limit per therapy per year.	$40 Copay	50% Coinsurance After Deductible
Physical Therapy 20 visit limit per year.	$40 Copay	50% Coinsurance After Deductible
Chiropractic Services 24 visit limit per year.	$40 Copay	50% Coinsurance After Deductible
ANCILLARY SERVICES		
Hospice Requires precertification.	10% Coinsurance After Deductible	50% Coinsurance After Deductible
Private Duty Nursing Care Inpatient, only when ICU is not available. Requires precertification.	10% Coinsurance After Deductible	50% Coinsurance After Deductible
Home Health Care Requires precertification. 60 days per year maximum.	10% Coinsurance After Deductible	50% Coinsurance After Deductible
MEDICAL EQUIPMENT		
Medical Equipment Requires precertification for items over $2,500 and all insulin pumps.	10% Coinsurance After Deductible	50% Coinsurance After Deductible
Prosthetics Coverage only applies to the initial purchase, fitting and repair.	10% Coinsurance After Deductible	50% Coinsurance After Deductible
Hearing Aids Coverage is limited to participants 18 years of age or younger for hearing loss that is not correctable by other covered procedures. Limited to one (1) hearing aid per ear every three (3) years.	10% Coinsurance After Deductible	50% Coinsurance After Deductible
Medically Necessary Wigs	$1000 Lifetime Maximum	

PRESCRIPTION DRUG SERVICES		
	Retail (per 30-day supply)	**Mail Order (per 90-day Supply)**
Generic	Full Rx Plan: $5 Copay Generic Only Plan: $15 Copay	Full Rx Plan: $10 Copay Generic Only Plan: $30 Copay
Brand Formulary	Full Rx Plan: $30 Copay Generic Only Plan: Not Covered	Full Rx Plan: $60 Copay Generic Only Plan: Not Covered
Brand Non-Formulary	Full Rx Plan: $50 Copay Generic Only Plan: Not Covered	Full Rx Plan: $100 Copay Generic Only Plan: Not Covered
Specialty Drugs	Full Rx Plan: 20% Coinsurance up to $150 Generic Only Plan: Not Covered	(Only available up to a 30-day supply)

Covered Medical Expenses

Covered Expenses are subject to the Usual and Customary Charges as determined by HealthEZ.

1. **Ambulance.** Professional land or air service, if medically necessary, to the nearest Hospital or Skilled Nursing Facility. Ground ambulance capitation of $5,000 per event and air ambulance capitation of $15,000 per event.

2. **Behavioral Therapy.** Treatment of observable behaviors that applies the principals of learning to substitute desirable responses and behavior patterns for undesirable ones.

3. **Cardiac Rehabilitation.** Following a myocardial infarction, coronary occlusion, or coronary bypass surgery.

4. **Chemotherapy and Radiation Therapy.**

5. **Chiropractic services.** When performed by a licensed M.D., D.O. or D.C.

6. **Clinical Trials.** Routine patient costs for participation in an Approved Clinical Trial**.** Charges relating to the prevention, detection, or treatment of a life-threatening disease or condition, as defined under the PPACA, provided the clinical trial is approved by:

    - The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
    - The National Institute of Health;
    - The U.S. Food and Drug Administration;
    - The U.S. Department of Defense; or
    - The U.S. Department of Veterans Affairs.

7. **Contact Lenses.** The initial contact lenses required following cataract surgery.

8. **Contraceptives.** The charges for all FDA approved contraceptive methods are covered in accordance with Health Resources and Services Administration (HRSA) guidelines.

9. **Dental Services.** When recommended by a physician and incurred during a dental procedure, facility and anesthesia charges are covered for a child under age 5; an individual who is severely disabled; or an individual who has a medical condition.

10. **Diabetes Supplies, Equipment and Devices.**

11. **Hearing Aids and Exams.** Services in connection with hearing aids or exams for their fitting or for hearing loss if not due to Illness or Injury, only for participants 18 or younger, for hearing loss that is not correctable by other covered procedures.

12. **Home Health Care Services and Supplies.** When a Hospital or Skilled Nursing Facility would otherwise be required. The care must be prescribed by the attending Physician and be contained in a Home Health Care Plan. A Home Health Care Service visit is defined as a periodic visit by a nurse or therapist, or four hours of home health aide services.

13. **Hospice Care Services and Supplies.** When the patient is not expected to live more than six months, as certified by a Physician, and is placed under a Hospice Care Plan.

14. **Hospital Care.** After 23 observation hours, charges will be considered under inpatient confinement.

15. **Implantable Device.** An invoice must be included and represent the actual cost (net amount, exclusive of rebates and discounts) for the implantable device. The maximum allowable under the Plan is 135% of the documented invoice amount.

    In the event the implant invoice is not obtained by the Plan, the plan will have the discretionary authority to apply for a Reasonable payment, the PPO discount and/or audit negotiation in place of the calculation based on the actual billing.

16. **Infertility**. Diagnosis and surgical correction of physical abnormalities.

17. **Mental Disorders and Substance Abuse.** Treatment when billed by a Physician (M.D.), licensed consulting psychologists (Ph.D.), or licensed consulting Master of Social Work (M.S.W.). Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

18. **Medical/Surgical Equipment Purchase or Rentals.** Rental costs cannot exceed the fair market value of the equipment.

19. **Obesity.** Treatment for weight loss, dietary control, or Morbid Obesity. Bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. $100,000 lifetime maximum.

20. **Occupational / Physical Therapy.** Rendered by a licensed therapist. Therapy must be rehabilitative and result from an Injury or Sickness other than a learning or Mental Disorder.

21. **Oral Procedures.**

    - Excision of tumors and cysts;
    - Surgery needed to correct injuries;
    - Excision of benign bony growths;
    - External incision and drainage of cellulitis;
    - Incision of sensory sinuses, salivary glands or ducts; or
    - Temporomandibular joint syndrome (TMJ).

22. **Organ transplant**. When performed at a **Designated Center of Excellence for Transplants**.

23. **Obtaining donor organs or tissues.** When the donor has medical coverage, his or her plan will pay first. Donor charges include those for:

    - Evaluating the organ or tissue;
    - Removing the organ or tissue from the donor; and
    - Transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

24. **Orthotic Appliances.** The initial purchase, fitting, and repair of non-foot orthotics when required for support of an injured or deformed body part.

25. **Pregnancy.** Routine Prenatal is covered as Preventive Care.

26. **Preventive and Wellness Care for Adults and Children**. In accordance with Federal Law, benefits are available for evidence-based items or services that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

A list of Preventive and Wellness Services can be found at:
www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ or
www.healthcare.gov/preventive-care-benefits

27. **Private Duty Nursing Care.** Rendered by a licensed nurse (R.N., L.P.N. or L.V.N.) when care is not Custodial in nature, or when the hospital has no Intensive Care Unit or is filled.

28. **Prosthetic Devices.** The initial purchase, fitting, and repair of devices which replace body parts.

29. **Reconstructive Surgery.** Non-cosmetic procedures, including mammoplasties.

30. **Skilled Nursing Facility.** Covered when:

    - The patient is confined as an inpatient in the facility;
    - The attending Physician certifies that confinement is needed; and
    - The attending Physician completes a treatment plan.

31. **Smoking Cessation.** To the extent required by law and when under the treatment of a Physician.

32. **Speech therapy**. Rendered by a licensed speech therapist and ordered by a Physician. Must follow a surgery, Injury, or Sickness, other than a learning or Mental Disorder.

33. **Surgeons Fees.**

    - If bilateral or multiple surgical procedures are performed, 50% of the Usual and Customary Charge will be allowed for each additional procedure performed through the same incision. Any unrelated procedure will be considered "incidental" and no benefits will be provided for such procedures. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits will not exceed the Usual and Customary percentage allowed for that procedure; and

    - If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Customary allowance.

34. **Sterilization.** To the extent required by the Patient Protection and Affordable Care Act (PPACA).

35. **Wigs.** Non-cosmetic, for medically certified conditions.

Care Management Services

Care Management Services Phone Number: 1-877-241-6310

The patient or family member must call to receive certification of certain Care Management Services. This call must be made at least 48 hours in advance of services being rendered or within 48 hours after an emergency.

UTILIZATION REVIEW
Utilization review is designed to help ensure that all Plan Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

1. Precertification of the Medical Necessity for certain non-Emergency services before services are provided;

2. Concurrent review of the listed services requested by the attending Physician; and

3. Planning for discharge or cessation of medical treatment.

If a course of treatment or medical service is not certified, it means that the Plan may not pay in full for the charges. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

Precertification

The utilization review program is set in motion by a telephone call from the Plan Participant or provider. Please call **at least 48 before** services are scheduled with the following information:

- The name of the patient and relationship to the Employee.
- The name, ID number, and address of the Employee.
- The name and telephone number of the Physician.
- The name of the Medical Care Facility, the proposed date of admission, and the proposed length of stay.
- The diagnosis and/or type of surgery or treatment.

If there is an **Emergency** admission to the Facility, the utilization review administrator must be contacted **within 48 hours** of the first business day after the admission.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Failure to pre-certify required service may result in denial of or reduction in payment for services.

Precertification may be required for the following services:

- Hospitalizations
- Mental Health and Substance Abuse Treatments

- MRI/CT/PET Scans
- Surgeries
- Occupational, Behavioral, and Speech Therapy
- Skilled Nursing Care, Private Duty Nursing, Hospice and Home Health Care
- Medical Equipment over $2,500 and all insulin pumps.

Boost Your Baby- Maternity Management

Moms-to-be are identified, assisted, and followed by a Mommy Mentor to support a healthy Pregnancy. Those determined to be high risk are placed with a nurse in Care Management. All moms in Boost Your Baby are followed monthly and through six months post-delivery.

Alternative Care Plans

When determined to be medically necessary, alternative benefits not covered by the plan may be approved on a case-by-case basis.

A care manager consults with the patient, the family, and the Physician to develop a plan of care. Once a plan has been implemented, HealthEZ will direct the Plan to reimburse for expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Plan Exclusions

Note: Please see Prescription Drug Coverage for exclusions related to Prescriptions Drugs.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered unless deemed to be Medically Necessary by HealthEZ.

1. **Abortions.** Except to save the life of the mother, when caused by rape or incest, or the fetus has been diagnosed with a lethal abnormality.

2. **Alcohol.** Ordered evaluation or treatment which occurred as a result of the Plan Participant's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. This exclusion does not apply if the Injury resulted from being the victim of an act of domestic violence.

3. **Alternative Medicine/Therapies**. This includes acupuncture, acupressure, aromatherapy, biofeedback, kinetic therapy, hypnotherapy, homeopathic medicine; massage therapy, and neurofeedback, among others.

4. **Behavior Therapy Treatment.** Programs for the treatment of autism spectrum disorders.

5. **Blood Products.** Collection and/or storage of blood products to include stem cells or non-covered medical procedures. Salvage and storage of umbilical cord.

6. **Breast Implants.** Including replacement and removal of breast implants.

7. **Cochlear Implants.**

8. **Communications and Accessibility Services.** Provider charges for interpretation, translation, accessibility or other special accommodations. Devices and computers to assist in communication and speech, including professional sign language or foreign language interpreter services.

9. **Complications of Non-Covered treatments.** Treatment required as a result of a complication from a non-covered service under the Plan.

10. **Cosmetic Surgery/Services.** Medical, surgical, and mental health services for or related to cosmetic surgery or procedures.

11. **Counseling Services.** Counseling for educational, social, occupational, religious or other maladjustments.

12. **Court or Police Ordered Services.** Examinations, reports, or appearances in connections with legal proceedings, including child custody, competency issues, parole and/or probation, and other court-ordered related issues.

13. **Custodial Care.** Non-medical assistance for activities of daily life, or maintenance.

14. **Dental Services**. The medical portion of the Plan covers only those dental services specifically stated in the section titled Covered Medical Benefits.

15. **Diabetic Supplies, Equipment and Devices.** Non-covered services include the following:

    - Over-the-counter supplies, medications, and equipment;
    - Take home medications, supplies, and equipment after discharge from a Hospital, Nursing Home, Skilled Nursing Facility or other Inpatient or Outpatient facility.

16. **Educational evaluations or vocational testing.** Exams or other services for employment, insurance, licensure, judicial or administrative proceedings or research.

17. **Exercise.** Equipment, programs, clothing, or devices for treatment of any condition.

18. **Experimental or Investigational Treatment.**

19. **Eye care.** Eye Exercises, Orthoptic and Vision Therapy, Radial keratotomy, Lasik or other eye surgery to correct refractive disorders.

20. **Facility Charges.** Treatment provided at group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters, or foster homes.

21. **Foot care.** Unless related to diabetic care, treatment of weak, strained, flat, unstable or unbalanced feet, and treatment of corns, calluses or toenails. Shoes; shoe lifts; corrective shoes; shoe inserts and arch supports.

22. **Foreign travel.** Non-emergency related treatment outside of the U.S.

23. **Genetic Testing, Amniocentesis.** Services performed solely for the purpose of determining the gender or paternity of a fetus, or for a patient that is asymptomatic.

24. **Hair loss (cosmetic.)** Treatment including wigs, hair transplants or any drug for hair growth.

25. **Hazardous Pursuit, Hobby or Activity.** Treatment that results from engaging in a hazardous pursuit of extreme sports or activity.

26. **Home Maternity Services.** Deliveries at home including Doula and birth coach expenses.

27. **Hospital-based Infusion Therapy.** Intravenous-administered services provided in a Hospital-based setting

28. **Illegal acts.** Resulting from a Serious Illegal Act, a riot or public disturbance. Including:

    - The use of illegal drugs, or
    - Use of medications not administered on the advice of a Physician.

    For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence of a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed or result in a conviction.

29. **Impotence/Sexual Dysfunction.** Behavioral Treatment or medication regardless of the cause of the dysfunction.

30. **Infertility Treatment.**

31. **Maintenance Therapy.** Treatment after an individual has reached the maximum level of improvement.

32. **Malpractice**. Services required to treat injuries or illnesses including infections and complications that are contracted while under the care of a provider that are not reasonably expected to occur. This includes but is not limited to: surgery on the wrong body part, foreign object left in the patient after surgery, electric shock, burn, or fall while confined in a facility.

33. **Medical Equipment.** Examples include, but are not limited to, the following:

    - Exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, and hygienic equipment;
    - Equipment for a patient in an institution that is ordinarily provided by an institution, such as wheelchairs, hospital beds, and oxygen tents;
    - More than one device designed to provide essentially the same function;
    - Deluxe, electric, model upgrades, specialized, customized or other non-standard equipment.
    - Scooters and other power operated vehicles;
    - Warning devices, stethoscopes, blood pressure cuffs;
    - Repair, replacement or routine maintenance of equipment or parts due to misuse or abuse;
    - Over-the-counter braces and other devices, prophylactic braces; braces used primarily for sports activities;
    - Replacement of braces of the leg, arm, back, neck, or artificial arms or legs;
    - Communication devices (speech generating devices) and/or training to use such devices;
    - Bionic and hydraulic devices;
    - Oxygen when services are outside of the Service Area and non-emergent or urgent, or when used for convenience;
    - Personal comfort items such as compression stockings and Transcutaneous Electrical Nerve Stimulation (TENS) units.

34. **Non-Compliance.** Treatments or medications where the patient either is in non-compliance or is discharged from a Hospital, Mental Health or Substance Abuse Facility against medical advice.

35. **Non-Emergency Ambulance Services/ Hospital Admissions.**

36. **Nutrition.** Infant formulas or other internal supplementation. Services of nutritionists and dietitians.

37. **Occupational Services.** Charges that arise from work for wage or profit, including self-employment.

38. **Over-the-Counter Medical Supplies and Medications.**

39. **Physical and Psychiatric Exams.** Testing and/or other services in connection with obtaining or maintaining employment, school or camp attendance or insurance qualification, or any type of license or medical research.

40. **Private Duty Nursing.** Charges for outpatient private duty nursing care, treatment or services.

41. **Rehabilitation/Habilitative Services.** Maintenance and/or non-Acute therapies; or therapies where a significant and measurable improvement of a condition cannot be expected in a Reasonable and predictable period of time.

42. **Self-Inflicted Deliberate Injury.** Unless resulting from being the victim of an act of domestic violence or a medical condition (including both physical and mental health conditions).

43. **Sex Changes.** Non-congenital transsexualism, gender dysphoria or sexual reassignment or change. Including medications, implants, hormone therapy, surgery, medical, or psychiatric treatment.

44. **Surrogate Mother Pregnancies.**

45. **Temporomandibular Joint Disorder**

    - Dental splints, dental prosthesis or any treatment on or to the teeth, gums, or jaws;
    - Treatment of pain or infection due to a dental cause, surgical correction of malocclusion, maxilla facial orthognathic and prognathic surgery, orthodontia treatment.

46. **Transportation, Travel or Accommodations.**

47. **War and Riots.** Expenses caused by or arising out of riots, insurrection, rebellion, armed invasion, or aggression.

Defined Terms

These terms have significant meaning and when used in this Plan Document will be capitalized.

1. **Adverse Benefit Determination.** A failure to provide or make payment (in whole or in part) for a benefit. This includes: denials, reduction, termination, or rescission.

2. **Allowable Expenses.** The dollar amount considered payment in full by an insurance plan. The allowable charge is a discounted rate rather than the actual charge.

3. **Approved Clinical Trial**. means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services ("CMS"), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required).

   The Patient Protection and Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

   A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate.

   "Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out-of-network benefits are otherwise provided under the Plan.

4. **Assignment of Benefit.** An arrangement by which a patient requests that their health benefit payments be made directly to a designated Physician or facility.

5. **Birthing Center**. A licensed, free-standing health facility which is not a Hospital or in a Hospital, where births occur. The Birthing center must provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications.

6. **Centers of Excellence.** Medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the best outcomes in performing transplant procedures and the best survival rates. HealthEZ shall determine what Network Centers of Excellence are to be used.

7. **Child.** Employee's own blood descendant of the first degree, a stepchild, lawfully adopted Child, or a Child placed with a covered Employee in anticipation of legal adoption, and/or a covered Employee's Child who is an alternate recipient under a "Qualified Medical Child Support Order" required by law.

8. **CHIPRA.** The Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act. www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra

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

10. **Clean Claim.** A Claim that can be processed in accordance with the terms of this document without obtaining additional information from the service provider or a third party. It is a claim which has no defect or impropriety. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customary, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

11. **Claim**. A detailed invoice that your healthcare provider sends to your health plan. This invoice shows the services you received**.**

12. **COBRA.** The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. https://www.dol.gov/general/topic/health-plans/cobra

13. **Covered Expense.** A service or treatment which is eligible for coverage in this plan.

14. **Custodial Care.** Services that are rendered for assistance in daily living that can be provided safely and reasonably by individuals who are neither skilled nor licensed medical personnel.

15. **Dependent** – A spouse, Domestic Partner, or Child who is eligible for coverage.

16. **Domestic Partner.** An unrelated and unmarried person who shares living quarters with an Employee and relies on the Employee for more than one half of his or her support for the plan year. Refer to your employee handbook for qualifications.

17. **Emergency.** A serious, unexpected, or dangerous situation requiring immediate medical attention.

18. **Employee.** A person who is employed by the Plan Sponsor and eligible for coverage.

    The following definitions are associated with the Code Section 4980H (Employer Shared Responsibility) as enacted under the Affordable Care Act:

    - **Administrative Period.** A period of time used by the Employer to determine if Variable Hour Employees and/or Ongoing Employees are eligible for coverage and, if so, to make an offer of coverage. An Administrative Period may not exceed 90 days. The Employer may choose not to use an Administrative Period.
    - **Full-time Employee or Full-Time Employment**. An Employee who is working an average of at least 30 hours of service per week with the Employer.
        - **New Employee**. An Employee who has not been employed by the Employer for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the Employee was credited with zero hours of service.
        - **Non-variable Hour Employee.** An Employee reasonably expected at the time of hire to work 30 or more hours per week.
        - **Ongoing Employee.** An Employee who has been employed by the Employer for at least one complete Measurement Period.
        - **Seasonal Employee.** An Employee who is hired into a position for which the customary annual employment is six months or less.
        - **Variable Hour Employee**. An Employee, based on the facts and circumstances at the Employee's start date, for whom a reasonable expectation of average hours per week cannot be determined.

- **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 the employer 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.
- **Measurement Period**. The period of time selected by the Employer during which Variable Hour Employee's and/or Ongoing Employee's hours of service are tracked to determine the Employee's employment status for benefit purposes.
    - **Initial Measurement Period**: For a newly hired Variable Hour Employee, this Measurement Period will start from the date of hire and ends after a period of 3 to 12 consecutive months of service. The Employer determines the Initial Measurement Period and provides that information through its own internal procedures and documents, such as the Employee Handbook.
    - **Standard Measurement Period**: For Ongoing Employees, this Measurement Period will start at a time designated by the Employer and will last for a period of 3 to 12 consecutive months of service. The Employer determines the Standard Measurement Period and provides that information through its own internal procedures and documents, such as the Employee Handbook.
- **Stability Period**. Used by the Employer as part of the Look-back Measurement Method. The Stability Period is a period of time equal to the Measurement Period in which the Variable Hour Employee's and/or Ongoing Employee's eligibility status is fixed.

19. **Effective Date**. The first day of coverage.

20. **ERISA**. The Employee Retirement Income Security Act of 1974, as amended. www.dol.gov/general/topic/retirement/erisa

21. **Essential Health Benefits.** A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, and mental health services

22. **Experimental and/or Investigational.** Services or treatments that are not United States Food and Drug Administration (FDA) approved. Services or treatments which are not widely used or accepted by most practitioners or lack credible evidence, and that are not the subject of, or related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment.

23. **Family.** The covered Employee and the Dependents who are covered under the Plan.

24. **FMLA.** Family and Medical Leave Act of 1993, as amended. www.dol.gov/general/topic/benefits-leave/fmla

25. **FMLA Leave** is a leave of absence, which the employer is required to extend to an Employee.

26. **Formulary.** A list of covered prescription medications compiled by the Pharmacy Benefit Manager.

27. **Generic Drug**. A Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration.

28. **GINA**. The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information. www.dol.gov/agencies/ebsa/laws-and-regulations/laws/gina

29. **HIPAA**. The Health Insurance Portability and Accountability Act of 1996, as amended. www.hhs.gov/hipaa/index.html

30. **Home Health Care Agency.** An organization whose main function is to provide Home Health Care Services and Supplies; The agency must be federally certified and licensed by the state in which it is operating.

31. **Home Health Care Plan**. A formal written plan made by the patient's attending Physician; which states the diagnosis and specifies the type and extent of Home Health Care required.

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

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

34. **Hospice Care Services and Supplies. T**hose provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, and home care. See the Schedule of Benefits to determine whether this includes family counseling during the bereavement period.

35. **Hospital.** An institution which is engaged primarily in providing medical care is accredited as a Hospital by The Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; is approved by Medicare as a Hospital; The definition of "Hospital" shall be expanded to include the following: A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

36. **Illness.** A bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

37. **Incurred**. A Covered Expense is “Incurred” on the date the service is rendered, or the supply is obtained.

38. **Infertility.** Incapable of producing offspring.

39. **Injury.** A physical Injury to the body caused by unexpected or external means.

40. **Intensive Care Unit.** A department of a hospital of which patients who are dangerously ill are kept under constant observation.

41. **Legal Guardian.** A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual.

42. **Maximum Allowable.** The benefit payable for a covered expense item the Plan.

    Note: HealthEZ has the discretionary authority to decide if a charge is Reasonable, Usual and Customary and Medically Necessary. The Plan will reimburse out of network charges at the billed rate if it is less than the Reasonable amount. This amount will not include any billing mistakes including, up-coding, duplicate charges and services not performed.

43. **Medical Care Necessity**, **Medically Necessary**, **Medical Necessity.** Health care services ordered by a licensed Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's Sickness or Injury without adversely affecting the Plan Participant's medical condition.

    (1) It must not be maintenance therapy or maintenance treatment;

    (2) Its purpose must be to restore health;

    (3) It must not be primarily custodial in nature;

    (4) It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare);

    (5) The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

    For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Plan Participant is receiving or the severity of the Plan Participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

    To be Medically Necessary, all these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the FDA and HealthEZ's own medical advisors. HealthEZ has the discretionary authority to decide whether care or treatment is Medically Necessary.

44. **Medical Equipment.** Equipment and supplies ordered by a healthcare provider for everyday or extended use.

45. **Medicare**. The Health Insurance for the Aged and Disabled under Title XVIII of the Social Security Act, as amended. www.medicare.gov

46. **Mental Disorder.** A disease or condition is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

47. **Morbid Obesity.** A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Plan Participant.

48. **No-Fault Coverage.** The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

49. **Open Enrollment**. The yearly period when employees can enroll in benefits.

50. **Outpatient Services.** Medical procedures or tests that can be done in a medical center without an overnight stay.

51. **Partial Hospitalization.** A structured program of outpatient psychiatric or substance abuse services. This treatment is provided during the day and does not require an overnight stay.

52. **Pharmacy.** An establishment where covered Prescription Drugs are filled and dispensed by a licensed pharmacist.

53. **Physician**. A Doctor of Medicine (M.D.), Osteopathy (D.O.), Podiatric Medicine (D.P.M.), Chiropractic (D.C.), Dental Surgery (D.D.S), or Optometry (O.D). Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Licensed Professional Occupational Therapist, Psychiatrist, Psychologist (Ph.D.), or Licensed Professional Speech Language Pathologist. All physicians must be practicing within the scope of their license.

54. **Plan.** Valley-Wide Health Systems, Inc. Medical Plan, which is a benefit plan for eligible Employees.

55. **Plan Participant.** An Employee or Dependent who is covered under this Plan.

56. **Plan Sponsor.** Valley-Wide Health Systems, Inc.

57. **Provider**. A health professional who provides health care services.

58. **Plan Year.** A twelve-month period of benefits coverage. This 12-month period may not be the same as a calendar year.

59. **Prenatal.** Existing or occurring before birth.

60. **Prescription Drug.** A pharmaceutical drug that legally requires a medical prescription to be dispensed.

61. **Preventive Care**. Routine healthcare that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. This plan complies with Patient Protection and Affordable Care Act's (PPACA).

62. **Reasonable** and/or **Reasonableness.** In the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the HealthEZ.

    This determination will consider the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. HealthEZ retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to HealthEZ. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

63. **Rehabilitative.** The process of helping a person who has suffered an Illness or Injury, restore lost skills and regain maximum self-sufficiency.

64. **Sickness.** A person's Illness, disease or Pregnancy (including complications).

65. **Skilled Nursing Facility.** A facility that fully meets all of these tests: Its services are provided for compensation and under the full-time supervision of a Physician; It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse; It maintains a complete medical record on each patient; It has an effective utilization review plan; The ability to store and dispense Prescription Drugs; and, It is approved and licensed by Medicare. This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

66. **Special Enrollment Period**. A time outside the yearly Open Enrollment Period when you can enroll in benefits. You qualify for a Special Enrollment Period if you've had certain life qualifying events.

67. **Substance Abuse.** Any use of alcohol, any drug (whether obtained legally or illegally), or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

    - Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home
    - Recurrent substance use in situations in which it is physically hazardous
    - Craving or a strong desire or urge to use a substance;
    - Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

68. **Substance Abuse Treatment Center.** A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse. This Institution must be: **affiliated** with a Hospital under a contractual agreement with an established system for patient referral; **accredited** as such a facility by The Joint Commission on Accreditation of Hospitals; or **licensed**, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

69. **Temporomandibular Joint** (TMJ) **Syndrome**. Jaw joint disorders, including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular joint.

70. Usual and Customary (U&C). Covered Expenses which are identified by HealthEZ, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates.

The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is Incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of a person of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. HealthEZ will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at HealthEZ's discretion, alternatively be determined and established by the Plan using normative data such as, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Prescription Drug Coverage

Participating pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. Contact your pharmacy benefit manager for more information.

If a drug is purchased from a non-participating pharmacy or when the Plan Participant's ID card is not used, the total amount eligible for benefits will be the ingredient cost and the dispensing fee.

Prior Authorization
Certain prescription drugs require a Prior Authorization. This means a review of a medication prescribed will be done before the plan will cover it. A prior authorization may be required for drugs listed or not listed on the Pharmacy Benefit Manager's (PBM) formulary.

Expenses Not Covered

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

1. **Appetite suppressants.** A charge for appetite suppressants, dietary supplements, or vitamin supplements, except for Prenatal vitamins requiring a prescription, or prescription vitamin supplements containing fluoride.

2. **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A, or medications for hair growth or removal.

3. **Experimental, Investigational, or non-FDA Approved.**

4. **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance. Human Growth Hormone except for children or adolescents who have one of the following conditions:

    - Documented growth hormone deficiency causing slow growth;
    - Documented growth hormone deficiency causing infantile hypoglycemia;
    - SHOX
    - Short stature and growth due to Turner syndrome, Prader-Willi syndrome, chronic renal insufficiency prior to transplantation, central nervous system tumor treated with radiation;
    - Documented growth hormone deficiency due to a hypothalamic or pituitary condition.

5. **Impotence.** A charge for impotence medication.

6. **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

7. **Inpatient medication.** A drug or medicine that is to be taken while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

8. **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

9. **Copay Assistance.** A charge for Prescription Drugs which may be properly received without charge under local, state, or federal programs.

10. **Off-Label drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

11. **No prescription.** A drug or medicine that can legally be bought without a written prescription.

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

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How to Submit a Claim

In-Network Providers will submit Claims directly to HealthEZ. When a Plan Participant has an out of network claim to submit for consideration, they must submit:

- Member ID
- Employee's name
- Patient's Name
- Name, address, tax ID, NPI, and telephone number of the Provider of care
- Type of services rendered, with diagnosis and procedure codes
- Date of service(s)
- Receipt

Send information to HealthEZ:

Mail – PO Box 211186, Eagan, MN 55121
Email- service@healthez.com

WHEN CLAIMS SHOULD BE FILED

Claims should be filed as soon as possible; prompt filing is within 90 days from the service date. HealthEZ will not consider claims filed more than one year after the service date. Benefits are applied based on the date of service.

HealthEZ reserves the right to request more information from the Plan Participant or provider.

TIMEFRAMES

The following timetable applies:	
Notification to Plan Participant of a benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by the Plan Participant following notice of insufficient information	45 days
Review of Adverse Benefit Determination	30 days after benefit appeal

Notice to the Plan Participant of Adverse Benefit Determinations

HealthEZ will provide the Plan Participant with notification of an Adverse Benefit Determination, setting forth:

- A reference to the specific portion(s) of the plan upon which a denial is based;
- Specific reason(s) for a denial;
- A description of available appeals;
- A description of the Plan's review procedures;
- A statement that the Plan Participant is entitled to receive copies of information relevant to the Plan Participant's claim;

- Any rule considered in making the determination;
- In the case of denials based upon a medical judgment, an explanation of the scientific or clinical judgment for the determination will be provided.

Appeals

When a Plan Participant receives an Adverse Benefit Determination, the Plan Participant has 180 days following receipt of the notification in which to appeal the decision. A Plan Participant may submit written comments, documents, records, and other information relating to the Claim. If the Plan Participant requests, he or she will be provided access to information relevant to the Claim.

The decision timeline begins at the time an appeal is filed without regard to whether all the necessary information accompanies the filing.

Information is relevant to a Claim if it was considered in the course of making the determination, regardless of whether it was relied upon.

The review shall take into account all information submitted by the Plan Participant relating to the Claim. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, the fiduciary shall consult with a healthcare professional.

External Review Process

The Federal external review process does not apply to a determination based on lack of eligibility.

The Federal external review process applies only to:

- An Adverse Benefit Determination that involves medical judgment as determined by the external reviewer; and
- A denial of coverage.

Standard external review

1. Request for external review. A Plan Participant must file a request for external review within 180 days after the receipt of an Adverse Benefit Determination. The Plan Participant can only file a request for external review after a First Level Appeal determination has been issued.

2. Preliminary review. Within 5 business days following the receipt of the external review request, the Plan will complete a preliminary review to determine whether:
    - The Plan Participant is or was covered under the Plan at the time the service was requested;
    - The Plan Participant has exhausted the Plan's First Level Appeal process; and
    - The Plan Participant has provided all the information required to process an external review.

   HealthEZ will issue a notification to the Plan Participant once the review is completed. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information needed to make the request complete and the Plan will allow a Plan Participant to amend the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an accredited independent review organization to conduct the external review.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination, the Plan will provide payment for the claim without delay, regardless of whether the plan intends to seek judicial review.

Expedited External Review
A Plan Participant may request an expedited external review when the Adverse Benefit Determination involves a medical condition for which the timeframe of a standard appeal would seriously jeopardize the health of the Plan Participant.

Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

A Plan Participant will not be required to exhaust the internal appeals process if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Plan Participant may proceed immediately to the External Review Program or make a claim in court. However, if the violation is not likely to cause harm to the Plan Participant, HealthEZ demonstrates that it was for good cause or due to matters beyond their control, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Plan Participant, and the violation is not reflective of a pattern or practice of non-compliance, then the Plan Participant will be required to follow the appeals process.

If a Plan Participant believes the has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Plan Participant may request that the Plan provide a written explanation of the violation and explain why violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis exception" described above, the Plan will provide the Plan Participant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

Recovery of Payments

Occasionally, benefits are paid in error. HealthEZ has the right to recover any erroneous payment directly from the entity who received it and/or from other payers and/or the Plan Participant on whose behalf the payment was made.

HealthEZ will have the sole discretion to choose who will repay an erroneous payment and whether such payment will be reimbursed in a lump sum. When an entity does not comply, HealthEZ will have the authority to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable by the amount due.

Any payments made in accordance with the above provisions will be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against an entity to enforce the provisions of this Plan, then that entity will pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Coordination of Benefits

Coordination of benefits sets out rules for the order of payment when two or more plans are paying.

Automobile Limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

1. Plans that do not have a coordination provision will pay first.

2. Plans with a coordination provision will pay their benefits up to the Allowable Charge in this order:

    I. The benefits of the plan which covers the person directly ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

    II. The benefits of a plan which covers a person as an Active Employee are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

    III. The plan which covers a person as an Active Employee or a Dependent of an Employee is determined before those of a plan which covers the person as a COBRA beneficiary.

    IV. When a child's parents are married, these rules will apply:

        - The plan of the parent whose birthday falls earlier in the calendar year is determined first.

        - If both parents have the same birthday, the plan which has covered the patient for the longer period is determined first.

    V. When a child's parents are divorced or legally separated, these rules will apply:

        - When the parent with custody has not remarried, their plan will be considered first.

        - When the parent with custody has remarried, their plan will be considered first. The plan of the stepparent will be considered next. The plan of the parent without custody will be considered last.

        - A court decree state may overrule the above and state which parent is financially responsible for medical and dental benefits of the child.

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

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

3. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether the person was enrolled under both parts.

4. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first.

End-Stage Renal Disease. When an individual is covered under this plan, the Plan will reimburse treatment for End-Stage Renal Disease (ESRD) for the initial 30 months at a rate not to exceed 135% of the Medicare allowable.

Subrogation

Payment Condition

1. The Plan may elect to conditionally advance payment of benefits in situations where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to No-Fault Coverage, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

2. The Plan Participant, their attorney, and/or the legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits. The Plan will have an equitable lien on any funds received by the Plan Participant and/or their attorney from any source and said funds shall be held in trust until the obligations under this provision are fully satisfied. The Plan Participant agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a Plan Participant settles, recovers, or is reimbursed by any Coverage, they agree to reimburse the Plan for all benefits paid conditionally. If the Plan Participant fails to reimburse the Plan, they will be responsible for any expenses associated with the Plan's attempt to recover the money.

4. If there is more than one party is responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties, of which the Plan Participant is only one, are considered as an "identifiable" fund from which the plan may seek reimbursement.

Plan Participants assign the right to subrogate and pursue claims that may arise against any individual, entity, or Coverage to HealthEZ. If a member receives benefits or becomes entitled to receive benefits, from any party causing their Sickness or Injury, an automatic equitable lien attaches in favor of the Plan to any claim the Plan Participant might have. The Plan may, at its discretion, in its own name or in the name of the Plan Participant, pursue such claims.

Assignment: If the Plan Participant fails to file a claim or pursue damages against a third party, they authorize the Plan to pursue such claims and will fully cooperate with the Plan to pursue a claim and the recovery of all expenses.

Right of Reimbursement

1. The Plan will be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan will have an equitable lien which supersedes all common law or statutory laws of any State prohibiting assignment of rights which interferes with the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs or litigation expenses, including expert's fees, may be deducted from the Plan's recovery. In addition, the Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant, whether under any doctrine in law.

3. These rights of subrogation and reimbursement do not require a separate written acknowledgment from Plan Participant and will not limit any other remedies of the Plan provided by law.

Separation of Funds

Benefits paid, funds recovered, and funds over which the Plan has an equitable lien exist separately from the estate of the Plan Participant. The Death of or filing of bankruptcy by the Plan Participant will not affect the Plan's lien or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event a wrongful death or survivor claim is asserted against a third party, the Plan's subrogation and reimbursement rights still apply.

Obligations

It is the Plan Participant's obligation:

- To fully cooperate with the Plan;
- To provide the Plan with pertinent information;
- To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- To promptly reimburse the Plan when a recovery or other payment is received; and
- To not settle or release any claim without the prior consent of the Plan.

Minor Status

In the event the Plan Participant is a minor, the minor's parents or guardian will cooperate in all actions by the Plan to seek and obtain requisite court approval to bind the minor and their estate insofar as these subrogation and reimbursement provisions are concerned. If the minor's parents or guardian fail to take such action, the Plan will have no obligation to advance payment of medical benefits on behalf of the minor and any court costs or legal fees associated with obtaining such approval will be paid by the minor's parents or guardian.

Offset

If Plan Participant or their attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant in an amount equivalent to what the Plan is owed.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan.

Continuation Coverage Rights Under COBRA

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Employees. The right to enroll in COBRA is triggered by the loss of coverage under the terms of the Plan. The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event.

FMLA qualified leaves do not constitute a Qualifying Event. However, if an Employee does not return to employment at the end of the FMLA leave, then that loss of coverage may be a Qualifying Event for COBRA.

What are the alternatives to COBRA? A Plan Participant has the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by their Spouse's employer) within 30 days after the coverage under this Plan ends. They will also have the same right at the end of COBRA coverage if they take COBRA for the maximum time available.

How long is the COBRA election period? The election period begins on the day the Plan Participant would lose coverage and ends 60 days after either that date, or the date the Plan Participant is provided notice of their right to elect COBRA, whichever is later.

The Plan Sponsor is responsible for notifying the COBRA Vendor within 30 days when the Qualifying Event is one of the following:

- End of employment or reduction of hours;
- Death of Employee;
- Employer bankruptcy proceeding; or
- Enrollment of Employee in Medicare.

IMPORTANT:

The Employee is responsible for notifying the Plan Sponsor within 60 days of the Qualifying Event if it is one of the following:

- Divorce;
- Legal separation; or
- Dependent Child's losing eligibility for coverage.

NOTICE PROCEDURES:

Any notice must be ***in writing***.
If mailed, the notice must be postmarked no later than the last day of the required notice period. The notice must state:

- The **name of the plan or plans** under which the Plan Participant lost coverage,
- The **name and address of the Employee** covered under the plan,
- The **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- The **Qualifying Event** and the **date** it happened.

HealthEZ reserves the right to request proof of the Qualifying Event.

Each Qualified Beneficiary has an independent right to elect COBRA. Covered Employees may elect COBRA for their spouses, and parents may elect COBRA on behalf of their children.

Can a waiver be revoked? If during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. However, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked).

Is COBRA available if a Qualified Beneficiary has other coverage? Qualified beneficiaries who are entitled to elect COBRA may do so even if they are covered under another group health plan or are entitled to Medicare benefits. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, they become entitled to Medicare or become covered under other group health plan coverage.

When will COBRA be terminated? COBRA will end on the earliest of the following dates:

- The last day of the maximum coverage period;
- The first day for which Timely Payment is not made;
- The date upon which the employer ceases to provide any group health plan;
- The date, after election, that the Qualified Beneficiary first enrolls in Medicare, or
- In the case of a Qualified Beneficiary in a disability extension period, the first day of the month more than 30 days after the final determination that the Plan Participant is no longer disabled.

What are the maximum coverage periods? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary:

1. If the Qualifying Event is a termination of employment or reduction of hours, the maximum coverage period is 18 months, or 29 months if there is a disability extension;

2. If an Employee is enrolled in Medicare before experiencing a termination of employment or reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than the Employee ends on the later of:

    - 36 months after the date the Employee enrolled in the Medicare program; or

    - 18 months (29 months, if there is a disability extension) after the date of the Employee's termination of employment or reduction of hours;

3. In the case of any other Qualifying Event than that described above, the maximum coverage period is 36 months.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18-month or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA coverage. To qualify for the disability extension, the Qualified Beneficiary must provide the COBRA vendor or Plan Sponsor with notice of the disability determination within 60 days of the determination.

Does the Plan require payment for COBRA continuation coverage? Qualified beneficiaries will pay 102% of the premium for the first 18 months and 150% of the premium for an expanded period of COBRA.

What is Timely Payment for payment for COBRA continuation coverage? First, a payment must be made within 30 days of the first day of the coverage period.

Notwithstanding the above paragraph, the Plan does not require payment earlier than 45 days after the election of COBRA.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES
In order to protect your family's rights, please keep HealthEZ informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to HealthEZ.

Responsibilities of Plan Administrator

PLAN ADMINISTRATOR. HealthEZ has maximum legal discretionary authority to interpret the Plan and to decide disputes which may arise. The decisions of HealthEZ will be final and binding on all interested parties.

The Plan pays for all expenses for plan administration. Legal proceedings may be initiated against HealthEZ once the appeals process has been exhausted.

FIDUCIARY. A fiduciary exercises discretionary authority or control, with prudence and diligence, over management and administration of the Plan.

THE NAMED FIDUCIARY. A named fiduciary can appoint others to carry out fiduciary responsibilities under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary is not liable for any act or omission of such person unless the named fiduciary breached its fiduciary responsibility.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

Funding is derived from the funds of the Plan Sponsor and contributions made by the covered Employees. Benefits are paid directly from the Plan by HealthEZ.

CLERICAL ERROR. Any clerical error in making any changes in eligibility will not invalidate coverage or continue coverage validly terminated. In the case of clerical error, the Plan will reimburse for the overpayment.

AMENDING AND TERMINATING THE PLAN. If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination. The Plan Sponsor intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend, or terminate the Plan.

SUMMARY OF MATERIAL MODIFICATION (SMM). A Summary of Material Modification reports changes in the Summary Plan Description.

The Plan Sponsor will notify all Plan Participants of any plan amendment considered a Summary of Material Modifications, no later than 210 days after the close of the Plan Year in which the changes became effective.

The Plan Sponsor will notify all Plan Participants of any plan amendment considered a reduction, no later than 60 days after adoption.

Note: If a Plan's Material Modifications are not reflected in the most recent Summary of Benefits and Coverage (SBC) then the Plan will provide written notice to Plan Participants at least 60 days before the effective date of the Modification.

Certain Plan Participants Rights under ERISA

ERISA specifies that all Plan Participants are entitled to:

- Examine, without charge, at HealthEZ's office, all Plan documents governing the Plan.
- Obtain copies of all Plan documents and other Plan information upon written request to HealthEZ. HealthEZ may make a Reasonable charge for the copies.
- Continue healthcare coverage under the Plan under certain circumstances

If a Plan Participant believes their rights have been violated, they may file suit in court, contact the nearest Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA), or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of EBSA Offices are available through EBSA's website.)

Important Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) NOTICE

If you have a mastectomy, the Women's Health and Cancer Rights Act of 1998 (WHCRA) entitles you to coverage for:

I. All stages of reconstruction of the breast on which the mastectomy was performed;
II. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
III. Prostheses; and Treatment of physical complications of mastectomy, including lymphedemas.

These benefits are subject to the same deductibles and coinsurance as other procedures.

GINA NOTICE

The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), prohibits discrimination on the basis of Genetic Information. GINA expands on HIPAA in several ways:

- Group health plans and health insurers cannot base premiums on Genetic Information;
- Plans and insurers are prohibited from requesting or requiring an individual to undergo a genetic test; and
- Plans and insurers are prohibited from collecting Genetic Information (including family history) prior to or in connection with enrollment, or for underwriting purposes.

NOTICE OF RIGHTS UNDER THE MOTHERS & NEWBORNS HEALTH PROTECTION ACT

Group health plans cannot restrict the hospital stay for the mother or newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Plans may not require that a provider obtain authorization for prescribing a length of stay up to 48 (or 96) hours either.

MENTAL HEALTH PARITY

The Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), enforce parity between covered health care benefits and covered mental health and substance disorder benefits.

COMPLIANCE WITH HIPAA PRIVACY AND PORTABILITY REQUIREMENTS

This Plan provides each Plan Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. **Additional copies of our Notice of Privacy Practices are available by contacting the HIPAA Compliance Officer.**

Qualified Medical Child Support Orders (QMCSCOs)

Please contact 1-877-241-6310 to request of a copy of the written procedures used by HealthEZ to determine QMCSCOs.

General Plan Information & Establishment of the Plan

Name of Plan:	Valley-Wide Health Systems, Inc. Medical Plan
Plan Sponsor (Named Fiduciary):	Valley-Wide Health Systems, Inc. 128 Market Street Alamosa, Colorado 81101
Plan Sponsor ID No. (EIN):	84-0706945
Source of Funding:	Self-Funded
Applicable Law:	ERISA
Plan Year:	August 1st to July 31st
Plan Number:	501
Plan Status:	Non-Grandfathered
Plan Type:	Medical Prescription Drug
Plan Administrator:	America's TPA dba HealthEZ P.O. Box 211186 Eagan, Minnesota 55121
Agent for Service of Process:	Valley-Wide Health Systems, Inc.
HIPAA Officer(s):	Alifonso Baroz and Marina Williams Ph: 719-587-1061 and 719-587-1053 baroza@vwhs.org and williamsm@vwhs.org

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this non-grandfathered Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

VALLEY-WIDE HEALTH SYSTEMS, INC.

By: Tania Arnoldi

Name: Tania Arnoldi

Title: CEO

Date: 6/27/19