CARSON TAHOE HEALTH SYSTEM

GROUP BENEFIT PLAN

AMENDMENT #1

AMENDMENT TO PLAN DOCUMENTS

CARSON TAHOE HEALTH SYSTEM

Effective January 1, 2026, the Carson Tahoe Health System Plan is amended as follows:

Page 35 and page 39 - Schedule of Eligible Medical Benefits

The exclusion of Autism from Eligible Medical Expenses #49 Speech Therapy and Medical Limitations and Exclusion #19 Learning & Behavioral Disorders is removed.

Eligible Medical Expenses

#49 is amended to read as follows:

49. Speech Therapy – Short-term active, progressive Speech Therapy performed by a licensed or duly qualified therapist as ordered by a Physician. Speech Therapy to restore speech to a person who has lost existing speech function as a result of disease, injury or surgery, such as seizure disorder, CVA or stroke, otitis media, brain injury, hearing loss, Parkinson's disease and paralysis of the vocal cord or larynx, carcinoma of the larynx, trachea, pharynx, lip, head, neck, and dysphasia.

NOTE: Speech Therapy is not covered for non-organic/functional speech and language disorders such as lisping, stuttering and stammering, or speech and language problems that result from non-curable developmental disorders such as developmental delay, mental retardation and Down's Syndrome. Maintenance therapy is not covered. Maintenance therapy begins when the therapeutic goals of a treatment plan have been met, and no further functional progress is expected.

Medical Limitations and Exclusions

#19 is amended to read as follows:

19. Learning & Behavioral Disorders – Except as noted, treatment for learning or behavioral disorders or mental retardation.

NOTE: See "Attention Deficit Disorders (ADD & ADHD)" and "Behavioral Health Care" in the list of **Eligible Medical Expenses** for coverage information.

Autism will be added to Eligible Medical Expenses:

Autism Spectrum Disorder – Screening for and diagnosis of autism spectrum disorders and applied behavior analysis treatment of autism spectrum disorders.

Evidence-based research means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

Habilitative or rehabilitative care means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the function of a person.

An initial assessment of the cognitive, communicative, social, emotional and behavioral condition and adaptive skill level of a child with autism spectrum disorder is conducted by a provider of health care acting within his or her scope of practice to determine the baseline of the child.

A subsequent assessment is conducted by a provider of health care acting within his or her scope of practice upon the child's conclusion of the early intervention services to determine the progress made by the child from the time of his or her initial screening.

Prescription care means medication prescribed by a licensed physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.

Screening for autism spectrum disorders means Medically Necessary assessments, evaluations or test to screen and diagnose whether a person has an autism spectrum disorder.
NOTE: Nothing in this section shall be construed as requiring an insurer to provide reimbursement to an early intervention agency or school for services delivered through early intervention or school services.

Benefits for Autism will be covered as normal behavioral health services under the mental health benefit on all plans offered by Carson Tahoe Health System.

Signed by:
Name: Katie Kucera
Title: CFO
Date: 2/9/2026 | 07:57 PST

CARSON TAHOE
HEALTH

Carson Tahoe Health System

GROUP HEALTH PLAN

PLAN DOCUMENT

Effective January 1, 2026

DIRECTORY OF SERVICE PROVIDERS

The following providers render services on behalf of the Plan. A Plan participant can contact the appropriate office when he or she has a question or needs help.

TYPE OF SERVICE	PROVIDER
Contract Administrator Handles the processing of claims in accordance with the Plan Document. A Covered Person can also obtain additional information about Plan coverage, treatment, procedures, preventive service, etc. from the Contract Administrator.	**Hometown Health** 10315 Professional Circle Reno, NV. 89521 775-982-5885 https://www.hometownhealth.com/carson-tahoe-health/
Pre-Certification/Utilization Management/Care Management Provides Pre-Certification/Utilization Management services, which are described under the section entitled "Utilization Management Program." Care Management is to assist patients with complex or chronic medical conditions. Hometown Health provides employees with a combination of patient advocacy, self-care education and one-on-one support by experienced health care professionals.	**Hometown Health** 10315 Professional Circle Reno, NV. 89521 775-982-5885 https://www.hometownhealth.com/carson-tahoe-health/
Preferred Provider Organization (PPO) for Medical Services Providers contracted to render services at discounted rates.	**Hometown Health** 10315 Professional Circle Reno, NV. 89521 https://www.hometownhealth.com/ carson-tahoe-health/
Preferred Provider Organization (PPO) for Medical Services - outside the state of Nevada Providers contracted to render services at discounted rates.	**Hometown Health – Cigna** 775-982-5885 Cigna | Hometown Health
Preferred Provider Organization (PPO) for Dental Services Providers contracted to render services at discounted rates. If Covered Person's dental Physician is a Non-PPO provider, application for membership can be made with Diversified Dental Services.	**Diversified Dental Services, Inc.** 1575 Delucchi Lane Suite 207A Reno, Nevada 89510 775-337-1180 www.ddsppo.com
Prescription Drug Vendor Provides a Network of participating retail pharmacies from which a Covered Person can obtain prescription medications by using their identification card. Provides information regarding formulary, mail order and out of network.	**VytlOne**320 S. Polk, Suite 200 Amarillo, TX 79101 **1-800-687-0707** VytlOneMembers.com
Plan Sponsor Human Resources Department	**Carson Tahoe Health System** 1600 Medical Parkway Carson City, Nevada 89503 775-445-8010

INTRODUCTION

This document is both the Summary Plan Description (SPD) and the Plan Document for the Carson Tahoe Health System (CTHS) Group Health Plan (the "Plan"), through which CTHS offers self-funded medical, dental and prescription benefit plans. Under the Plan, CTHS offers three (3) group medical plan options to eligible employees:

- **Plus Plan** – PPO plan that has the highest level of benefits of all of the plan options, with a lower annual out-of-pocket maximum.
- **Core Plan** – PPO plan that has higher deductibles, copayments and out-of-pocket maximums
- **High Deductible Health Plan (HDHP)** – HDHP has different features than the other Plan options. Under the HDHP you will have a higher deductible and all services other than preventive care are subject to the calendar year deductible and co-insurance maximums. The HDHP is compatible with a Health Savings Account (HSA).

How to use this Summary Plan Description (SPD)

- Please read this SPD carefully to be sure you understand the benefits, exclusions and general provisions of the Plan. It is your responsibility to keep informed about any changes in your health coverage.
- Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).
- Some of the terms used in the document begin with a capital letter. These terms have a special meaning and are included in the **DEFINITIONS** section. When reading the provisions of this Plan, it may be helpful to refer to this section. Becoming familiar with the terms defined there will give you a better understanding of the benefits and provisions.
- The **Table of Contents** lists the section titles and descriptions of what may be in that Section. It is a great place to go if you are looking for specific information.
- It is important that you review the **UTILIZATION MANAGEMENT PROGRAM** so you are aware of the **Pre-Certification Requirements.**
- The deductibles, coinsurance and benefit percentages can be found in the **MEDICAL BENEFIT SUMMARY** section for the plan option(s) you selected. This section contains only the highlights of the Plan and should not be relied on to determine the extent to which a service or benefit is covered or excluded.
- Services that are eligible can be found in the **ELIGIBLE MEDICAL EXPENSES** section and services that are not eligible can be found in the **MEDICAL LIMITATIONS AND EXCLUSIONS** and **GENERAL EXCLUSIONS** sections of the SPD.
- Many of the sections of the SPD are related to other sections of the SPD. You may not have all the information you need by reading just one section.

If you do not understand the **UTILIZATION MANAGEMENT PROGRAM,** a benefit or exclusion you can contact Hometown Health.

Contents

IMPORTANT NOTICES

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, for individuals receiving mastectomy-related benefits, this Plan provides coverage for: 1) All stages of reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and treatment of physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and which are consistent with those established for other medical and surgical benefits provided under the Plan.

DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the **Definitions** section. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined therein will provide a better understanding of the benefits and provisions.

NOTICE OF RIGHT TO RECEIVE A CERTIFICATE OF CREDITABLE COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Contract Administrator or its delegate. If Plan coverage or COBRA continuation coverage terminates, the Contract Administrator will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage).

PROHIBITION ON RESCISSIONS

The health care component plans in this Plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this Section shall not apply to a covered individual who has performed an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan or coverage. In any such event, such plan or coverage may not be rescinded except with at least 30 days' prior notice to the enrollee and any other participant who would be affected by the rescission, and only as permitted under Section 2701(c) or Section 2742(b) of the Patient Protection and Affordable Care Act (PPACA). Notwithstanding the foregoing, a retroactive termination of coverage due to a failure to pay a required contribution or ineligibility of an individual shall not be considered a "rescission" that is subject to the requirements in this Section.

PREGNANCY DISCRIMINATION ACT OF 1978

Most Employers must provide coverage for Pregnancy expenses in the same manner as coverage is provided for any other Illness. This requirement applies to Pregnancy expenses of an Employee or a covered Dependent spouse of an Employee.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")

GINA prohibits the Plan from:

1. Adjusting premiums or contribution amounts for a group of similarly situated individuals on the basis of Genetic Information.
2. Requesting or requiring an individual or a family member to undergo a genetic test. However, subject to certain conditions, the Plan may request that an individual voluntarily undergo a genetic test as part of a research study as long as the results are not used for underwriting purposes.
3. Requesting, requiring or purchasing Genetic Information for underwriting purposes (which includes eligibility rules or determinations, computation of premium or contribution amounts, and other activities related to the creation, renewal or replacement of coverage). The Plan is also prohibited from requesting, requiring or purchasing Genetic Information with respect to any individual prior to such individual's enrollment under the Plan or coverage. However, if the Plan obtains Genetic Information incidental to the collection of other information prior to enrollment, it will not be in violation of GINA as long as it is not used for underwriting purposes.

GINA allows the Plan to obtain and use the results of genetic tests for purposes of making payment determinations.

What is "Genetic Information" under GINA?

Under GINA, the term "Genetic Information" includes:

1. Information about an individual or his/her family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes);
2. Information about the manifestation of a Disease or disorder in the family members of the individual. Family members are broadly defined under GINA to include individuals who are Dependents, as well as any other first, second, third or fourth degree relative. Further, Genetic Information includes the genetic information of any fetus or embryo carried by an individual or by a pregnant woman who is a family member of the individual, and the genetic information of any embryo legally held by the individual or a family member using assisted reproductive technology; and
3. Information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.

   Genetic Information does not include the sex or age of an individual.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs; however, you may be able to buy individual insurance coverage through the Health Insurance Marketplace.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed in the annual Premium Assistance Under Medicaid and the Children's Health Insurance Program notice distributed by the Plan, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer- sponsored plan, such as the Plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

FAMILY AND MEDICAL LEAVE ACT OF 1993 (P.L. 103-3)

If a covered Employee ceases Active Employment due to an Employer-approved Family and Medical Leave Act Leave of Absence in accordance with the requirements of Public Law 103, the Employee's coverage under the Plan will continue under the same terms and conditions which would have applied had the Employee continued in Active Employment during the period of the protected leave. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification). The Employee will be responsible for timely payment of any and all required contributions towards Plan premiums.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (H.R. 3103, 1996)

The Health Insurance Portability and Accountability Act (HIPAA) amended the Employee Retirement Income Security Act of 1974 (ERISA), and was enacted, among other things, to improve portability and continuity of health care coverage and to ensure that an individual's "protected health information" is subject to safeguards. Covered Persons will receive or have received a "privacy notice" that describes the important uses and disclosures of protected health information and your rights under HIPAA.

UTILIZATION MANAGEMENT PROGRAM

The purpose of the Utilization Management Program is to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. The health care professionals in the Medical Management department of Hometown Health Plan will focus their review on the necessity and appropriateness of hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services. A list of services that are reviewed is available at

Prior-Auth-Request-Form-HUM_SW-11.28.22.pdf

The fact that your physician recommends surgery, hospitalization, or confinement in a skilled nursing/sub- acute facility, or that your physician or other health care provider proposes any other medical services or supplies doesn't mean the recommended services or supplies will be considered medically necessary for determining coverage under the Plan.

The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Medical Management's certification that a service is medically necessary doesn't mean a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, or if the services were not covered by the Plan, either in whole or in part.

PRE-CERTIFICATION REVIEW REQUIREMENTS

Contact Medical Management to comply with the medical and pharmacy Pre-Certification Review Requirements to avoid a penalty for non-compliance.

Hometown Health

10315 Professional Circle
Reno, NV. 89521

775-982-3744 (F)

Out-of-Network Services – For all services and treatment not available from a PPO provider, pre- certification is required at least five (5) working days prior to receiving services from a Non-PPO provider. If pre-certification for the services is not obtained, then the benefits for the services may be subject to the non-compliance penalt**y** and the Non-PPO out-of-network benefit level. For information about benefits available to offset travel expenses in the event a Covered Person travels to University of Utah Health for services not available in the PPO network, see the **University of Utah Health Care Travel Reimbursement Benefit** section below.

Transplants (organ and tissue) – All pre-transplant-related expenses, including the admission for transplant services, must be pre-certified by Medical Management. For information about benefits available to offset travel expenses in the event a Covered Person travels to University of Utah Health Care for services not available in the PPO network, see the **University of Utah Health Care Travel Reimbursement Benefit** section below.

NOTE: The Plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining pre-service review impossible or where application of the pre-service review process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).

Please see the **Claims Procedures** section for the Plan's timeframes for review of pre-service claims.

UNIVERSITY OF UTAH HEALTH
TRAVEL REIMBURSEMENT BENEFIT

The Travel Reimbursement Benefit is available to offset the cost of travel for a Covered Person who travels to **University of Utah Health** for services that are not available in the PPO network and have been approved by Medical Management. Travel Reimbursement Benefit allowances are listed below. The Affiliated Providers benefit level will be applied to pre-certified services received at University of Utah Health.

Calendar Year Limit	$10,000
Airfare, Rental Car, Mileage, Lodging, and Meals	Up to $2,400 per trip

After approved travel to University of Utah Health for services, individuals must complete a Utah Travel Reimbursement Benefit Form, attach all receipts and submit to Medical Management at Hometown Health Plans.

For more information on University of Utah Health visit healthcare.utah.edu.

CHOICE OF PROVIDERS

Hometown Health has contracted with a Preferred Provider Organization (PPO) of health care providers. When obtaining health care services, a Covered Person has a choice of using providers who are participating in the PPO network (PPO Providers) or any other Covered Providers of his/her choice (Non- PPO Providers). However, using a Non-PPO Provider could result in higher out-of-pocket expenses.

PPO Providers – PPO Providers have agreed to provide services at negotiated rates. When a Covered Person uses a PPO Provider, his/her out-of-pocket expenses may be reduced because the Covered PPO Provider will not balance bill the patient for expenses in excess of the PPO negotiated rate.

Non-PPO Providers – If you receive services from a Non-PPO Provider, your out-of-pocket expenses may be greater because the Non-PPO Provider's fees will be subject to the negotiated rate that would have been allowed for a PPO Provider, had you used one. Any excess amounts may be billed to the patient. The amount in excess of Usual and Customary expenses will not go towards the Individual or Family Out-of- Pocket Maximums.

Hometown Health
10315 Professional Circle
Reno, NV. 89521
775-982-5885
https://www.hometownhealth.com/carson-tahoe- health/

There may be circumstances when a PPO Provider cannot be used. Nevertheless, Non-PPO Providers will be paid at the Non-PPO benefit levels except in the following limited circumstances:

Emergency Hospital Admissions – If a Covered Person is admitted to a Non-PPO hospital following an emergency room visit, all such expenses will be paid at the PPO benefit levels, subject to approval by Medical Management (see **UTILIZATION MANAGEMENT PROGRAM** section), and until the patient's condition is stabilized. Upon stabilization, if the Covered Person does not transfer to a PPO Provider, care will be covered at the Non-PPO benefit levels.

Ancillary Services – Services of a Non-PPO ancillary provider (i.e. emergency room Physician, urgent care Physician, radiologist, pathologist, on-call Physician) will be covered at the PPO benefit levels if such services are received while a Covered Person is being treated in the emergency room of a PPO hospital, PPO Urgent Care Facility, PPO Ambulatory Surgery Center or confined in a PPO hospital facility.

Unavailable Services – If a Covered Person uses a Non-PPO Provider specialist because the necessary specialty is not represented in the PPO network or is not reasonably accessible to the patient due to geographic constraints, such Non-PPO specialist care will be covered at the PPO benefit levels. Services rendered outside the network because of unavailable services in the network must be approved by Medical Management (see **UTILIZATION MANAGEMENT PROGRAM** section).

Below is a list of the PPO Hospitals in Northern Nevada. These PPO Hospitals are eligible for the PPO benefit levels of the Plan (see the **Medical Benefit Summary**). To obtain a complete list of the PPO network, visit the website at https://www.hometownhealth.com/carson-tahoe- health/ See **Directory of Service Providers** for additional contact information.

- **Carson Tahoe Regional Medical Center** (Tier 1 Providers)
  1600 Medical Parkway Carson City, Nevada 89703
  https://www.carsontahoe.com/
  775-445-8000

- **Renown Regional Medical Center**
  1155 Mill Street
  Reno, NV 89502
  https://www.renown.org/
  775-982-5000

- **Renown South Meadows Medical Center**
  10101 Double R Blvd
  Reno, NV 89521

- **Northern Nevada Medical Center**
  2375 East Prater Way Sparks, Nevada 89434
  https://www.nnmc.com/
  775-331-7000

- **Northern Nevada Sierra Medical Center**
  6500 Longley Lane Reno, Nevada 89511
  Sierra Medical Center | Reno, Nevada
  775-799-7320

- **Saint Mary's Regional Medical Center**
  235 West Sixth Street Reno, Nevada 89503
  https://saintmarysreno.com/
  775-770-3000

CENTER OF EXCELLENCE

University of Utah Health is a designated Center of Excellence when services cannot be provided at a PPO Provider or facility and services have been pre-certified by Medical Management. See Out-of-Network Services and University of Utah Health Travel Benefit in the UTILIZATION MANAGEMENT PROGRAM section for further information. Eligible expenses from University of Utah Health will be processed at the CTHS and Affiliated Providers benefit level.

- **University of Utah Health**
  50 N. Medical Drive Salt Lake City, Utah 84132
  https://healthcare.utah.edu/

PLUS MEDICAL BENEFIT SUMMARY

Plan Name: Carson Tahoe Health Plus $500-$4500-20% Package

Employer Name: Carson Tahoe Health

Effective Period: From 01/01/2026 through 12/31/2026

Benefit Accrual Period: Calendar Year

Medical Care Deductible and Out of Pocket Maximum (OOPM)

General Cost Share & Features	CTHS	In-Network	Out-of-Network
Deductible: - Medical only.	$500 – self only; $500/ $1,000 – per person/family	$1,000 – self only; $1,000/$2,000 – per person/family	$2,000 – self only; $2,000/$4,000 – per person/family
The Deductible is the amount a Covered Person must contribute towards payments of eligible medical expenses. The Out-of-Network deductible amount is the maximum deducible that will be required. CTHS, In-Network, and Out-of-Network eligible medical expenses are combined for purposes of determining the maximum calendar year deductible.			
Out-of-Pocket Maximum:	$4,500 – self only; $4,500/$9,000 – per person/family	$4,500 – self only; $4,500/$9,000 – per person/family	$9,000 – self only; $9,000/$18,000 – per person/family
The OOPM is the maximum amount a Covered Person will pay for eligible medical expenses. CTHS, In-Network, and Out-of-Network eligible medical expenses are combined for the purposes of determining the maximum calendar year OOPM.			

Benefit	CTHS	In-Network	Out-of-Network
INPATIENT SERVICES*			
Inpatient Hospital, Surgical or Medical	20% after Deductible	30% after Deductible	50% after Deductible
Maternity Physician Services	20% after Deductible	30% after Deductible	50% after Deductible
Skilled Nursing Facility/Acute Rehab/Long Term Acute Care (Limited to 120 Days per calendar year combined)	30% after Deductible	30% after Deductible	50% after Deductible

Benefit	CTHS	In-Network	Out-of-Network
Hospice Care	20% after Deductible	30% after Deductible	50% after Deductible
Mental Health or Substance Abuse Facility	20% after Deductible	30% after Deductible	50% after Deductible
Residential Treatment Facility	20% after Deductible	30% after Deductible	50% after Deductible
OUTPATIENT SERVICES*			
Telehealth/Medical**** (Provided through Teladoc)	Not Applicable	No Charge	Not Applicable
Primary Care Provider (PCP) Office Visits	$20, Deductible Does Not Apply	$30, Deductible Does Not Apply	50% after Deductible
Specialist Office Visits	$40, Deductible Does Not Apply	$50, Deductible Does Not Apply	50% after Deductible
After Hours or Urgent Care Clinic	$40, Deductible Does Not Apply	$50, Deductible Does Not Apply	50% after Deductible
Mental Health or Substance Abuse Office Visit	$40, Deductible Does Not Apply	$50, Deductible Does Not Apply	50% after Deductible
Physical Therapy (Limited to 30 visits per Calendar Year)	20% after Deductible	30% after Deductible	50% after Deductible
Occupational Therapy (Limited to 30 visits per Calendar Year)	20% after Deductible	30% after Deductible	50% after Deductible
Respiratory Therapy (Limited to 30 visits per Calendar Year)	20% after Deductible	30% after Deductible	50% after Deductible
Speech Therapy (Limited to 30 visits per Calendar Year)	20% after Deductible	30% after Deductible	50% after Deductible
Outpatient Surgical Services	20% after Deductible	30% after Deductible	50% after Deductible
Other Medical Services Performed at an Outpatient Facility	20% after Deductible	30% after Deductible	50% after Deductible

Benefit	CTHS	In-Network	Out-of-Network
Allergy Treatment and Serum	20% after Deductible	30% after Deductible	50% after Deductible
Major Diagnostic Services (X-ray, MRI, PET and CT scans)	20% after Deductible	30% after Deductible	50% after Deductible
Minor Diagnostic Services (Laboratory)	No Charge	No Charge	50% after Deductible
Emergency Room - Copay Waived if admitted to the hospital	$200, Deductible Does Not Apply	30% after Deductible	30% after Deductible
Emergency Physician and Professional Services	20% after Deductible	30% after Deductible	30% after Deductible
Ambulance (Air or Ground) - Emergencies Only	Ambulance - Ground: Not Applicable Ambulance - Air: Not Applicable	Ambulance - Ground: $100, Deductible Does Not Apply Ambulance - Air: 30% after Deductible	Ambulance - Ground: $100, Deductible Does Not Apply Ambulance - Air: 30% after Deductible
PREVENTIVE SERVICES			
Primary Care Provider (PCP)	No Charge	No Charge	50% after Deductible
Specialist	No Charge	No Charge	50% after Deductible
Adult and Pediatric Immunizations	No Charge	No Charge	50% after Deductible
Elective Immunizations (herpes zoster (shingles), rotavirus) *	No Charge	No Charge	50% after Deductible
Minor Diagnostic Services	No Charge	No Charge	50% after Deductible
Other Preventive Services	No Charge	No Charge	50% after Deductible
OTHER BENEFITS*			
Durable Medical Equipment (DME)	Not Applicable	30% after Deductible	50% after Deductible
Injectable Drugs and Specialty Medications	20% after Deductible	30% after Deductible	50% after Deductible

Benefit	CTHS	In-Network	Out-of-Network
Bariatric Surgery (Limited to 1 Treatment per Lifetime)	Not Applicable	30% after Deductible	50% after Deductible
Hospice Care Provided at Home	Not Applicable	30% after Deductible	50% after Deductible
Home Health Care (Limited to 60 Visits per calendar year)	Not Applicable	30% after Deductible	50% after Deductible
Chiropractic & Acupuncture Services (Limited to 15 Visits per calendar year combined)	Not Applicable	$50, Deductible Does Not Apply	50% after Deductible
Diabetic Education and Related Nutritional Counseling (Subject to CTH Program Guidelines)	No Charge	30% after Deductible	Not Applicable
Nutritional Counseling (Limited to $1,000 per Calendar Year)	No Charge	$35, Deductible Does Not Apply	50% after Deductible
Temporomandibular Joint Dysfunction Treatment (TMJ) (Limited to $4,000 per Lifetime. Does not apply to Out-of-Pocket Maximum)	Not Applicable	30% Coinsurance	50% after Deductible
Medical Supplies	20% after Deductible	30% after Deductible	50% after Deductible

Prescription Benefits*

General Cost Share & Features	CTHS	In-Network	Out-of-Network
Deductible	$50 – per person	$50 – per person	Not Covered

RETAIL PHARMACY – UP TO 30 DAY SUPPLY			
Benefit	**CTHS**	**In-Network**	**Out-of-Network**
Tier 0 (Preventive Drugs)	No Charge	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	$15, Deductible Does Not Apply	$15, Deductible Does Not Apply	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	$30, after Deductible	$30, after Deductible	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	$60, after Deductible	$60, after Deductible	Not Covered
Tier 4 (Specialty Drugs)**	20%, after Deductible	20%, after Deductible	Not Covered

MAIL ORDER and 90 day at Retail Pharmacy - UP TO 90 DAY SUPPLY – SELECTED DRUGS			
Benefit	**CTHS**	**In-Network**	**Out-of-Network**
Tier 0 (Preventive Drugs)	No Charge	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	$30, Deductible Does Not Apply	$30, Deductible Does Not Apply	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	$60, after Deductible	$60, after Deductible	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	$120, after Deductible	$120, after Deductible	Not Covered
Tier 4 (Specialty Drugs)	Not Covered	Not Covered	Not Covered

Notice/Notes/Terms & Conditions:

* Preauthorization may be required. Generic medications required or member responsible for copay/coinsurance plus cost difference between brand name and generic medication.

** Specialty Drugs require Prior Authorization and must be filled through a designated Specialty Pharmacy. Select specialty drugs have a manufacturer coupon. The value of the coupon will offset the members' copay.

*** 90-day supply can be obtained through the designated Mail Order Pharmacy and at any in-network pharmacy for Tier 0, 1, 2, and 3 drugs, if covered.

**** If your plan has telehealth benefits listed only visits with your designated Telehealth Provider, Teladoc, are eligible for the Telehealth/Medical benefit. Visits with a Primary Care Provider (PCP) or Specialist will be subject to the applicable copay, coinsurance, and/or deductible, even if the visit is electronic by phone or computer.

Deductible Included in Out-of-Pocket Maximum. All deductible, copay and coinsurance amounts are based on the allowed amounts and not on the provider's billed charges. You are responsible for paying for excess charges

on covered services obtained from Out-of-Network providers and facilities. Excess charges are not applied to the Medical Out-of-Pocket Maximums.

To remain compliant with state and federal regulations, including the Affordable Care Act (ACA), these benefits are subject to change. (1) Primary Care Physicians are those with a primary specialty of General Medicine, Family Medicine, Internal Medicine, Pediatrics, and OB/Gyn. (2) Frequency and/or quantity limitations apply to some preventive care and medical supplies. (3) All covered services obtained outside the United States, except for urgent or emergency conditions, will be paid at the Out-of-Network benefit. (4) Certain exclusions or preauthorization may apply for services and prescription drugs. Please refer to your policy for more information.

For more information, please call Customer Service at 775-982-5885.

All benefits are administered by Hometown Health Plan.

CORE MEDICAL BENEFIT SUMMARY

Plan Name: Carson Tahoe Health Core $1000-$6850-20% Package

Employer Name: Carson Tahoe Health

Effective Period: From 01/01/2026 through 12/31/2026

Benefit Accrual Period: Calendar Year

Medical Care Deductible and Out of Pocket Maximum (OOPM)

General Cost Share & Features	CTHS	In-Network	Out-of-Network
Deductible: - Medical only.	$1,000 – self only; $1,000/ $2,000 – per person/family	$1,500 – self only; $1,500/$3,000 – per person/family	$3,000 – self only; $3,000/$6,000 – per person/family
The Deductible is the amount a Covered Person must contribute towards payments of eligible medical expenses. The Out-of-Network deductible amount is the maximum deducible that will be required. CTHS, In-Network, and Out-of-Network eligible medical expenses are combined for purposes of determining the maximum calendar year deductible.			
Out-of-Pocket Maximum:	$6,850 – self only; $6,850/$13,700 – per person/family	$6,850 – self only; $6,850/$13,700 – per person/family	$12,000 – self only; $12,000/$24,000 – per person/family
The OOPM is the maximum amount a Covered Person will pay for eligible medical expenses. CTHS, In-Network, and Out-of-Network eligible medical expenses are combined for the purposes of determining the maximum calendar year OOPM.			

Benefit	CTHS	In-Network	Out-of-Network
INPATIENT SERVICES*			
Inpatient Hospital, Surgical or Medical	20% after Deductible	30% after Deductible	50% after Deductible
Maternity Physician Services	20% after Deductible	30% after Deductible	50% after Deductible
Skilled Nursing Facility/Acute Rehab/Long Term Acute Care (Limited to 120 Days per calendar year combined)	30% after Deductible	30% after Deductible	50% after Deductible
Hospice Care	20% after Deductible	30% after Deductible	50% after Deductible

Benefit	CTHS	In-Network	Out-of-Network
Mental Health or Substance Abuse Facility	20% after Deductible	30% after Deductible	50% after Deductible
Residential Treatment Facility	20% after Deductible	30% after Deductible	50% after Deductible
OUTPATIENT SERVICES*			
Telehealth/Medical**** (Provided through Teladoc)	Not Applicable	No Charge	Not Applicable
Primary Care Provider (PCP) Office Visits	$25, Deductible Does Not Apply	$35, Deductible Does Not Apply	50% after Deductible
Specialist Office Visits	$40, Deductible Does Not Apply	$50, Deductible Does Not Apply	50% after Deductible
After Hours or Urgent Care Clinic	$40, Deductible Does Not Apply	$50, Deductible Does Not Apply	50% after Deductible
Mental Health or Substance Abuse Office Visit	$40, Deductible Does Not Apply	$50, Deductible Does Not Apply	50% after Deductible
Physical Therapy (Limited to 30 visits per Calendar Year)	20% after Deductible	30% after Deductible	50% after Deductible
Occupational Therapy (Limited to 30 visits per Calendar Year)	20% after Deductible	30% after Deductible	50% after Deductible
Respiratory Therapy (Limited to 30 visits per Calendar Year)	20% after Deductible	30% after Deductible	50% after Deductible
Speech Therapy (Limited to 30 visits per Calendar Year)	20% after Deductible	30% after Deductible	50% after Deductible
Outpatient Surgical Services	20% after Deductible	30% after Deductible	50% after Deductible
Other Medical Services Performed at an Outpatient Facility	20% after Deductible	30% after Deductible	50% after Deductible
Allergy Treatment and Serum	20% after Deductible	30% after Deductible	50% after Deductible

Benefit	CTHS	In-Network	Out-of-Network
Major Diagnostic Services (X-ray, MRI, PET and CT Scans)	20% after Deductible	30% after Deductible	50% after Deductible
Minor Diagnostic Services (Laboratory)	No Charge	No Charge	50% after Deductible
Emergency Room - Copay Waived if admitted to the hospital	$200, Deductible Does Not Apply	30% after Deductible	30% after Deductible
Emergency Physician and Professional Services	20% after Deductible	30% after Deductible	30% after Deductible
Ambulance (Air or Ground) - Emergencies Only	Ambulance - Ground: Not Applicable Ambulance - Air: Not Applicable	Ambulance - Ground: $100, Deductible Does Not Apply Ambulance - Air: 30% after Deductible	Ambulance - Ground: $100, Deductible Does Not Apply Ambulance - Air: 30% after Deductible
PREVENTIVE SERVICES			
Primary Care Provider (PCP)	No Charge	No Charge	50% after Deductible
Specialist	No Charge	No Charge	50% after Deductible
Adult and Pediatric Immunizations	No Charge	No Charge	50% after Deductible
Elective Immunizations (herpes zoster (shingles), rotavirus)*	No Charge	No Charge	50% after Deductible
Minor Diagnostic Services	No Charge	No Charge	50% after Deductible
Other Preventive Services	No Charge	No Charge	50% after Deductible
OTHER BENEFITS*			
Durable Medical Equipment (DME)	Not Applicable	30% after Deductible	50% after Deductible
Injectable Drugs and Specialty Medications	20% after Deductible	30% after Deductible	50% after Deductible
Bariatric Surgery (Limited to 1 Treatment per Lifetime)	Not Applicable	30% after Deductible	50% after Deductible

Benefit	CTHS	In-Network	Out-of-Network
Hospice Care Provided at Home	Not Applicable	30% after Deductible	50% after Deductible
Home Health Care (Limited to 60 Visits per calendar year)	Not Applicable	30% after Deductible	50% after Deductible
Chiropractic & Acupuncture Services (Limited to 15 Visits per calendar year combined)	Not Applicable	$50, Deductible Does Not Apply	50% after Deductible
Diabetic Education and Related Nutritional Counseling (Subject to CTH Program Guidelines)	No Charge	30% after Deductible	Not Applicable
Nutritional Counseling (Limited to $1,000 per Calendar Year)	No Charge	$35, Deductible Does Not Apply	50% after Deductible
Temporomandibular Joint Dysfunction Treatment (TMJ) (Limited to $4,000 per Lifetime. Does not apply to Out-of-Pocket Maximum)	Not Applicable	30% Coinsurance	50% after Deductible
Medical Supplies	20% after Deductible	30% after Deductible	50% after Deductible

Prescription Benefits*

General Cost Share & Features	CTHS	In-Network	Out-of-Network
Deductible	$50 – per person	$50 – per person	Not Covered

RETAIL PHARMACY – UP TO 30 DAY SUPPLY			
Benefit	**CTHS**	**In-Network**	**Out-of-Network**
Tier 0 (Preventive Drugs & Specified Over the Counter Contraceptives)	No Charge	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	$15, Deductible Does Not Apply	$15, Deductible Does Not Apply	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	$30, after Deductible	$30, after Deductible	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	$60, after Deductible	$60, after Deductible	Not Covered
Tier 4 (Specialty Drugs) **	20%, after Deductible	20%, after Deductible	Not Covered

MAIL ORDER and 90 day at Retail Pharmacy*** - UP TO 90 DAY SUPPLY – SELECTED DRUGS			
Benefit	**CTHS**	**In-Network**	**Out-of-Network**
Tier 0 (Preventive Drugs)	No Charge	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	$30, Deductible Does Not Apply	$30, Deductible Does Not Apply	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	$60, after Deductible	$60, after Deductible	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	$120, after Deductible	$120, after Deductible	Not Covered
Tier 4 (Specialty Drugs)	Not Covered	Not Covered	Not Covered

Notice/Notes/Terms & Conditions:

* Preauthorization may be required. Generic medications required or member responsible for copay/coinsurance plus cost difference between brand name and generic medication.

** Specialty Drugs require Prior Authorization and must be filled through a designated Specialty Pharmacy. Select specialty drugs have a manufacturer coupon. The value of the coupon will offset the members' copay.

*** 90-day supply can be obtained through the designated Mail Order Pharmacy and at any in-network pharmacy, for Tier 0, 1, 2, and 3; drugs if covered.

**** If your plan has telehealth benefits listed only visits with your designated Telehealth Provider, Teladoc, are eligible for the Telehealth/Medical benefit. Visits with a Primary Care Provider (PCP) or Specialist will be subject to the applicable copay, coinsurance, and/or deductible, even if the visit is electronic by phone or computer.

Deductible Included in Out-of-Pocket Maximum. All deductible, copay and coinsurance amounts are based on

the allowed amounts and not on the provider's billed charges. You are responsible for paying for excess charges on covered services obtained from Out-of-Network providers and facilities. Excess charges are not applied to the Medical Out-of-Pocket Maximums.

To remain compliant with state and federal regulations, including the Affordable Care Act (ACA), these benefits are subject to change. (1) Primary Care Physicians are those with a primary specialty of General Medicine, Family Medicine, Internal Medicine, Pediatrics, and OB/Gyn. (2) Frequency and/or quantity limitations apply to some preventive care and medical supplies. (3) All covered services obtained outside the United States, except for urgent or emergency conditions, will be paid at the Out-of-Network benefit. (4) Certain exclusions or preauthorization may apply for services and prescription drugs. Please refer to your policy for more information.

For more information, please call Customer Service at 775-982-5885.

All benefits are administered by Hometown Health Plan.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) MEDICAL BENEFIT SUMMARY

This HDHP is compatible with a Health Savings Account (HSA)

HDHP – HSA COMPATIBLE

Plan Name: Carson Tahoe Health HDHP $3,200-$5000-20% Package

Employer Name: Carson Tahoe Health

Effective Period: From 01/01/2026 through 12/31/2026

Benefit Accrual Period: Calendar Year

Medical Care Deductible and Out of Pocket Maximum (OOPM)

General Cost Share & Features	CTHS	In-Network	Out-of-Network
Deductible: - Medical and Drug Combined.	$3,400 – self only; $3,400/ $6,400 – per person/family	$4,100 – self only; $4,100/$8,200 – per person/family	$6,100 – self only; $6,100/$12,200 – per person/family
The Deductible is the amount a Covered Person must contribute towards payments of eligible medical expenses. The Out-of-Network deductible amount is the maximum deducible that will be required. CTHS, In-Network, and Out-of-Network eligible medical expenses are combined for purposes of determining the maximum calendar year deductible.			
Out-of-Pocket Maximum:	$5,000 – self only; $5,000/$10,000 – per person/family	$5,000 – self only; $5,000/$10,000 – per person/family	$10,000 – self only; $10,000/$20,000 – per person/family
The OOPM is the maximum amount a Covered Person will pay for eligible medical expenses. CTHS, In-Network, and Out-of-Network eligible medical expenses are combined for the purposes of determining the maximum calendar year OOPM.			

Benefit	CTHS	In-Network	Out-of-Network
INPATIENT SERVICES*			
Inpatient Hospital, Surgical or Medical	20% after Deductible	30% after Deductible	50% after Deductible
Maternity Physician Services	20% after Deductible	30% after Deductible	50% after Deductible
Skilled Nursing Facility/Acute Rehab/Long Term Acute Care (Limited to 120 Days per calendar year combined)	30% after Deductible	30% after Deductible	50% after Deductible

Benefit	CTHS	In-Network	Out-of-Network
Hospice Care (Limited to 6 Months every 3 years)	20% after Deductible	30% after Deductible	50% after Deductible
Mental Health or Substance Abuse Facility	20% after Deductible	30% after Deductible	50% after Deductible
Residential Treatment Facility	20% after Deductible	30% after Deductible	50% after Deductible
OUTPATIENT SERVICES*			
Telehealth/Medical**** (Provided through Teladocl)	Not Applicable	No Charge	Not Applicable
Primary Care Provider (PCP) Office Visits	20% after Deductible	30% after Deductible	50% after Deductible
Specialist Office Visits	20% after Deductible	30% after Deductible	50% after Deductible
After Hours or Urgent Care Clinic	20% after Deductible	30% after Deductible	50% after Deductible
Mental Health or Substance Abuse Office Visit	20% after Deductible	30% after Deductible	50% after Deductible
Physical Therapy (Limited to 30 visits per Calendar Year)	20% after Deductible	30% after Deductible	50% after Deductible
Occupational Therapy (Limited to 30 visits per Calendar Year)	20% after Deductible	30% after Deductible	50% after Deductible
Respiratory Therapy (Limited to 30 visits per Calendar Year)	20% after Deductible	30% after Deductible	50% after Deductible
Speech Therapy (Limited to 30 visits per Calendar Year)	20% after Deductible	30% after Deductible	50% after Deductible
Outpatient Surgical Services	20% after Deductible	30% after Deductible	50% after Deductible
Other Medical Services Performed at an Outpatient Facility	20% after Deductible	30% after Deductible	50% after Deductible

Benefit	CTHS	In-Network	Out-of-Network
Allergy Treatment and Serum	20% after Deductible	30% after Deductible	50% after Deductible
Major Diagnostic Services (X-ray, MRI, PET and CT scans)	20% after Deductible	30% after Deductible	50% after Deductible
Minor Diagnostic Services (Laboratory)	20% after Deductible	30% after Deductible	50% after Deductible
Emergency Room	20% after Deductible	30% after Deductible	30% after Deductible
Emergency Physician and Professional Services	20% after Deductible	30% after Deductible	30% after Deductible
Ambulance (Air or Ground) - Emergencies Only	**Ambulance - Ground:** Not Applicable **Ambulance - Air:** Not Applicable	**Ambulance - Ground:** 30% after Deductible **Ambulance - Air:** 30% after Deductible	**Ambulance - Ground:** 30% after Deductible **Ambulance - Air:** 30% after Deductible
PREVENTIVE SERVICES			
Primary Care Provider (PCP)	No Charge	No Charge	50% after Deductible
Specialist	No Charge	No Charge	50% after Deductible
Adult and Pediatric Immunizations	No Charge	No Charge	50% after Deductible
Elective Immunizations (herpes zoster (shingles), rotavirus) *	No Charge	No Charge	50% after Deductible
Minor Diagnostic Services	No Charge	No Charge	50% after Deductible
Other Preventive Services	No Charge	No Charge	50% after Deductible
OTHER BENEFITS*			
Durable Medical Equipment (DME)	Not Applicable	30% after Deductible	50% after Deductible
Injectable Drugs and Specialty Medications	20% after Deductible	30% after Deductible	50% after Deductible
Bariatric Surgery (Limited to 1 Treatment per Lifetime)	Not Applicable	30% after Deductible	50% after Deductible

Benefit	CTHS	In-Network	Out-of-Network
Hospice Care Provided at Home	Not Applicable	30% after Deductible	50% after Deductible
Home Health Care (Limited to 60 Visits per calendar year)	Not Applicable	30% after Deductible	50% after Deductible
Chiropractic Services (Limited to 15 Visits per calendar year)	Not Applicable	30% after Deductible	50% after Deductible
Diabetic Education and Related Nutritional Counseling (Subject to CTH Program Guidelines)	20% after Deductible	30% after Deductible	Not Applicable
Nutritional Counseling (Limited to $1,000 per Calendar Year)	20% after Deductible	30% after Deductible	50% after Deductible
Temporomandibular Joint Dysfunction Treatment (TMJ) (Limited to $4,000 per Lifetime. Does not apply to Out-of-Pocket Maximum)	Not Applicable	30% coinsurance	50% after Deductible
Medical Supplies	20% after Deductible	30% after Deductible	50% after Deductible

Prescription Benefits*

RETAIL PHARMACY – UP TO 30 DAY SUPPLY			
Benefit	**CTHS**	**In-Network**	**Out-of-Network**
Tier 0 (Preventive Drugs)	No Charge	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	20%, after Deductible	20%, after Deductible	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	20%, after Deductible	20%, after Deductible	Not Covered

RETAIL PHARMACY – UP TO 30 DAY SUPPLY			
Benefit	**CTHS**	**In-Network**	**Out-of-Network**
Tier 3 (Non-Preferred Brand Drugs)	20%, after Deductible	20%, after Deductible	Not Covered
Tier 4 (Specialty Drugs)**	20%, after Deductible	20%, after Deductible	Not Covered

MAIL ORDER and 90 day at Retail Pharmacy*** - UP TO 90 DAY SUPPLY – SELECTED DRUGS			
Benefit	**CTHS**	**In-Network**	**Out-of-Network**
Tier 0 (Preventive Drugs)	No Charge	No Charge	Not Covered
Tier 1 (Preferred Generic Drugs)	20%, after Deductible	20%, after Deductible	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic)	20%, after Deductible	20%, after Deductible	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	20%, after Deductible	20%, after Deductible	Not Covered
Tier 4 (Specialty Drugs)	Not Covered	Not Covered	Not Covered

Special Maintenance Drug Benefit - UP TO 90 DAY SUPPLY – SELECTED DRUGS			
Benefit	**CTHS**	**In-Network**	**Out-of-Network**
Tier 1 (Limited Preferred Generic Drugs)	No Charge	No Charge	Not Covered
Tier 2 (Limited Preferred Brand and Non-Preferred Generic)	No Charge	No Charge	Not Covered

Note: A limited number of medications fall under the Special Maintenance Drug Benefit. This benefit allows certain Tier 1 and Tier 2 prescriptions to be covered at no cost to members, without meeting deductible and/or out of pocket maximum. Medications designated under the Special Maintenance Drug benefit will show on the preferred drug list/formulary marked with an "M" indicating Special Maintenance Drug benefit.

Notice/Notes/Terms & Conditions:

* Preauthorization may be required. Generic medications required or member responsible for copay/coinsurance plus cost difference between brand name and generic medication.

** Specialty Drugs require Prior Authorization and must be filled through a designated Specialty Pharmacy. Select specialty drugs have a manufacturer coupon. The value of the coupon will offset the members' copay.

*** 90-day supply can be obtained through the designated Mail Order Pharmacy and at any in-network pharmacies, for Tier 0, 1, 2, and 3 drugs, if covered.

**** If your plan has telehealth benefits listed only visits with your designated Telehealth Provider, Teladoc, are eligible for the Telehealth/Medical benefit. Visits with a Primary Care Provider (PCP) or Specialist will be subject to the applicable copay, coinsurance, and/or deductible, even if the visit is electronic by phone or computer.

Deductible Included in Out-of-Pocket Maximum. All deductible, copay and coinsurance amounts are based on the allowed amounts and not on the provider's billed charges. You are responsible for paying for excess charges on covered services obtained from Out-of-Network providers and facilities. Excess charges are not applied to the Medical Out-of-Pocket Maximums.

To remain compliant with state and federal regulations, including the Affordable Care Act (ACA), these benefits are subject to change. (1) Primary Care Physicians are those with a primary specialty of General Medicine, Family Medicine, Internal Medicine, Pediatrics, and OB/Gyn. (2) Frequency and/or quantity limitations apply to some preventive care and medical supplies. (3) All covered services obtained outside the United States, except for urgent or emergency conditions, will be paid at the Out-of-Network benefit. (4) Certain exclusions or preauthorization may apply for services and prescription drugs. Please refer to your policy for more information.

For more information, please call Customer Service at 775-982-5885.

All benefits are administered by Hometown Health Plans.

ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions which are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined (application of Deductible requirements and benefit sharing percentages, etc.). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted below or in the **Medical Benefit Summary**, eligible medical expenses are the Usual and Customary and Reasonable charges for the items listed below and which are incurred by a Covered Person – subject to the **Definitions**, **Limitations and Exclusions** and all other provisions of the Plan. In general, services and supplies must be provided by a Physician or other appropriate Covered Provider and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care conditions. Medically Necessary, however, does not guarantee that a service or supply is covered under the terms of the Plan.

For benefit purposes, medical expenses will be deemed to be incurred on:

- the date a purchase is made; or
- the actual date a service is rendered.

1. **Acupuncture / Acupressure –** Needle puncture or application of pressure at specific points on the body, whether used to cure disease, to relieve pain or as a form of anesthesia for Surgery.
2. **Alcoholism –** see "Substance Use Disorder"
3. **Allergy Testing & Serum**
4. **Ambulance –** Professional ground or air ambulance service: (1) when necessary to transport a Covered Person from the place where he/she is injured or stricken by a Sickness to the nearest Hospital where treatment can be given, (2) when Medically Necessary to transport a Covered Person to medical facilities and back home, or (3) when used to transport a Covered Person to a PPO Hospital.
5. **Ambulatory Surgical Center –** Services and supplies provided by an Ambulatory Surgical Center (see **Definitions**) in connection with a covered Outpatient Surgery.
6. **Anesthesia –** Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.
7. **Attention Deficit Disorders (ADD & ADHD) –** Treatment (i.e., periodic Physician check-ups for evaluation and medication management) for attention deficit disorder (ADD) or attention deficit hyperactive disorder (ADHD).

   NOTE: See **"Behavioral Health Care".**
8. **Behavioral Health Care –** Behavioral health care includes inpatient and outpatient services for a mental disorder identified in the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM). Behavioral health disorders may include but are not limited to: attention deficit disorders (ADD, ADHD), bereavement counseling, bipolar disorder, depression, marriage and family counseling, obsessive- compulsive disorder (OCD), panic disorder, schizophrenia and phobias.
9. **Birthing Center –** Services and supplies provided by a Birthing Center (see **Definitions**) in connection with a covered Pregnancy.

10. **Blood –** Blood and blood plasma (if not replaced by or for the patient), including blood processing and administration services. The Plan will also cover processing, up to 8 weeks of storage, and administration services for autologous blood (a patient's own blood) when such Covered Person is scheduled for a Surgery that can reasonably be expected to require blood.

11. **Cardiac Rehabilitation –** A monitored exercise program directed at restoring both physiological and psychological well-being to individuals with heart disease. Services rendered must be:

    - under the supervision of a Physician.
    - in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery.
    - initiated within twelve (12) weeks after treatment for the medical condition ends; and
    - provided in a covered medical care facility as defined by the Plan. See definition of “Cardiac Rehabilitation” in the **Definitions** section.

    NOTE: Maintenance care will not be covered.

12. **Chemical Dependency –** see "Substance Use Disorder"

13. **Chemotherapy –** Professional services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

14. **Chiropractic-type Care / Spinal Manipulation –** Spinal manipulation and all related services and supplies including, but not limited to, application of a modality to one or more areas (e.g., hot or cold packs, mechanical traction, electrical stimulation, vasopneumatic devices, paraffin baths, microwave, whirlpool, diathermy and infrared).

15. **Circumcision –** Routine circumcision.

16. **Contraceptives –** The charges for all FDA approved contraceptives methods, in accordance with Health Resources and Services Administration (HRSA) guidelines.

17. **Diabetes Education Services –** Diabetes training and education services when requested by a Physician and Medically Necessary for the self-care and self-management of a person with diabetes. Services must be provided by a Certified Diabetes Educator or a Health Care Practitioner approved by the Contract Administrator or its designee and includes counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.

    Retraining when due to new techniques for the treatment of diabetes or when there has been a significant change in the person’s clinical condition or symptoms that requires modifications of self- management techniques.

18. **Diagnostic Lab & X-ray, Outpatient –** Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

19. **Dialysis Services –** Dialysis services, including the training of a person to assist the patient with home dialysis, when provided by a hospital, freestanding dialysis center or other appropriate Covered Provider.

20. **Durable Medical Equipment –** Rental of durable medical equipment (but not to exceed the fair market purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury. The decision to rent or purchase equipment shall be at the option of the Plan. Excess charges for deluxe equipment or devices will not be covered.

    Repair of purchased equipment will be covered when necessary to maintain its usability. Replacement of durable medical equipment will be covered only if: (1) needed due to a change in the patient's physical condition, or (2) it is likely to cost less to buy a replacement than to repair existing equipment or rent like equipment.

    "Durable medical equipment" includes such items as non-dental braces, crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, intermittent positive pressure breathing machines and dialysis equipment, etc., which: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home.

21. **Gender Reassignment** – Gender reassignment surgery consisting of any combination of the following when the following criteria is met:

    1) Requirements for mastectomy for female-to-male patients:

        - Single letter of referral from a qualified mental health professional; and
        - Persistent, well-documented gender dysphoria (see Appendix); and
        - Capacity to make a fully informed decision and to consent for treatment; and
        - Age of majority (18 years of age or older); and
        - If significant medical or mental health concerns are present, they must be reasonably well controlled.

    2) Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female):

        - Two referral letters from qualified mental health professionals, one in a purely evaluative role (see Appendix); and
        - Persistent, well-documented gender dysphoria (see Appendix); and
        - Capacity to make a fully informed decision and to consent for treatment; and
        - Age of majority (18 years or older); and
        - If significant medical or mental health concerns are present, they must be reasonably well controlled; and
        - Twelve months of continuous hormone therapy as appropriate to the Covered Person's gender goals (unless the Covered Person has a medical contraindication or is otherwise unable or unwilling to take hormones).

3) Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male to female):

   - Two referral letters from qualified mental health professionals, one in a purely evaluative role (see Appendix); and
   - Persistent, well-documented gender dysphoria (see Appendix); and
   - Capacity to make a fully informed decision and to consent for treatment; and
   - Age of majority (age 18 years and older); and
   - If significant medical or mental health concerns are present, they must be reasonably well controlled; and
   - Twelve months of continuous hormone therapy as appropriate to the Covered Person's gender goals (unless the Covered Person has a medical contraindication or is otherwise unable or unwilling to take hormones); and
   - Twelve months of living in a gender role that is congruent with their gender identity (real life experience).

NOTE: See Gender Reassignment under **MEDICAL LIMITATIONS AND EXCLUSIONS** for services and procedures that are not covered.

22. **Genetic Counseling & Testing –** Counseling and testing services as follows:

- **Counseling:** when provided before and/or after BRAC1 and BRAC2 genetic tests.
- **Testing:** BRAC1 and BRAC2 genetic test for an individual already diagnosed with breast and/or ovarian cancer where results may affect the course of treatment.

NOTE: See **"Pregnancy"** for prenatal genetic testing.

23. **Home Health Care –** Services and supplies which are furnished to a Covered Person who is confined at home and is under the active medical supervision of the Physician ordering home health care and who is treating the condition for which that care is needed. Home health care services and supplies must be consistent with the patient's health condition, degree of disability and medical needs.

Home health care services and/or supplies must be provided and billed by a Home Health Care Agency. Covered home health care services and supplies include:

- services of a registered nurse (RN) or a licensed practical nurse (LPN);
- services of physical, occupational and speech therapists.
- services of a medical social service worker.
- services of home health aides who are employed by (or under an arrangement with) a Home Health Care Agency, provided the patient is also receiving nursing care and care of a therapist (see above). Services must be ordered by the Home Health Agency as a professional coordinator.
- necessary medical supplies provided by the Home Health Care Agency.

24. **Hospice Care –** Care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less) who has been admitted to a formal program of Hospice care. Eligible Expenses include Hospice program charges for:

    - Inpatient hospice care.
    - Physician services.
    - services of a Home Health Care Agency – see "Home Health Care" (above) for additional information.
    - drugs and medications; and
    - home health aide.

25. **Hospital Services –** Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and ancillary services and supplies.

    NOTE: Comfort or convenience items provided to a Covered Person while hospitalized are not covered.

26. **Infertility Testing –** Testing that is performed to determine a diagnosis for infertility (i.e., to determine the cause for infertility).

27. **Marriage & Family Counseling – see** "Behavioral Health Care"

28. **Medical Foods for Inherited Metabolic Disorders –** Medical foods (also called Special Food Products as defined below) are payable for persons with Inherited Metabolic Disorders (defined below), subject to the following provisions as determined by the Contract Administrator or its designee:

    - treatment must be prescribed by a Physician.
    - documentation to substantiate the presence of an Inherited Metabolic Disorder and that the products purchased are Special Food Products may be required.
    - For these purposes, "Inherited Metabolic Disorder" means genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates or fats, as diagnosed by a Physician using standard blood, urine, spinal fluid, and tissue or enzyme analysis. Inherited Metabolic Disorders are also referred to as inborn errors or metabolism and includes Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance with a diagnosis of Galactosemia is not covered.
    - A "Special Food Product" is a food product that is specially formulated to have less than one (1) Gram of protein per serving and is intended to be consumed under the direction of a Physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein or foods or formulas for people who do not have Inherited Metabolic Disorders.

29. **Medical Supplies –** Medical supplies such as casts, splints, trusses, surgical dressings, catheters, colostomy bags and related supplies.

30. **Medications –** Medical drugs are covered under the medical benefit. Claims Retail medications are covered under the Prescription Drug Benefit below.

31. **Midwife –** Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy – see **"Pregnancy"** below.

32. **Newborn Care –** Hospital nursery and Physician services provided during the birth confinement to a covered well newborn child.

    In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Hospital stay for a newborn (birth confinement) to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean delivery.

    NOTE: A covered newborn who is sick or injured is eligible for benefits to the same extent as any other Covered Person.

33. **Nutritional Counseling –** Services of a Registered Dietician for dietary or nutritional services.

34. **Nursing Services –** Services of a registered nurse (RN), licensed vocational nurse (LVN) or licensed practical nurse (LPN) for nursing services when prescribed in writing by the attending Physician or surgeon specifically as to duration and type. Inpatient nursing care is covered only when care is Medically Necessary and not custodial and the Hospital's Intensive Care Unit is filled, or the Hospital has no Intensive Care Unit. Outpatient nursing care is covered only as part of "Home Health Care" or "Hospice Care", above.

    NOTE: Services of a private surgical scrub nurse are not covered.

35. **Occupational Therapy –** Short-term active, progressive Occupational Therapy performed by a licensed or duly qualified therapist as ordered by a Physician.

    Services that are restorative in nature and designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, or injury and only if there is a reasonable expectation that occupational therapy will achieve measurable improvement in the patient's condition in a reasonable and predictable amount of time. See NOTE.

    NOTE: Occupational Therapy will not be covered for the management of chronic diseases, training in non-essential tasks (e.g. homemaking, gardening, and recreational activities), therapy related solely to specific employment opportunities, work skills or work settings and maintenance therapy. Maintenance therapy is defined as ongoing therapy after the patient has reached maximum rehabilitative level, and patient's functionality has not shown significant improvement.

36. **Orthognathic Surgery –** Surgery to correct a receding or protruding jaw.

    NOTE: Plan coverage does not include methods of treatment which are recognized as dental procedures (e.g., extraction of teeth, night guards and/or the application of braces to the teeth).

37. **Orthopedic Shoes & Braces –** Orthopedic braces and orthopedic shoes.

38. **Oxygen –** see "Durable Medical Equipment"**.**

39. **Physical Therapy –** Short-term active, progressive Physical Therapy performed by a licensed or duly qualified therapist as ordered by a Physician. Services that are related to an injury, illness, or disease and the diagnosis is consistent with physical therapy treatment. There must be reasonable expectation that the services will produce significant improvement in the patient's condition.

40. **Pregnancy** – Eligible Pregnancy-related expenses are covered to the same extent as any other Sickness. Pregnancy-related expenses including the following, but may include other services which are deemed to be **Medically Necessary**:

    - Prenatal visits and routine prenatal and post-partum care.
    - Expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of pregnancy.
    - Amniocentesis, chorionic villus sampling (CVS), fetoscopy and alpha-fetoprotein (AFP) analysis, Early Screen for Down Syndrome, Trisomy 18 and Trisomy 13, and cystic fibrosis in pregnant women, but only if the procedure is **Medically Necessary**.
    - Routine well-baby nursery expenses which are billed by the Hospital, and which are incurred during the child's birth confinement and while the mother and child are both confined post- delivery.

41. **Preventive and Wellness Care –** Focuses on evaluating your current health status when you are symptom free and allows you to obtain early diagnosis and treatment to help avoid more serious health problems. Preventive care services are not provided for specific health issues or conditions, on-going care, laboratory tests or health conditions.

    In compliance with the Patient Protection and Affordable Care Act (PPCA), benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

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

    With respect to infants, children, adolescents and adults, evidence-informed preventive care services and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, American Academy of Family Physicians and American Academy of Pediatrics/Bright Futures.

    With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services: well-woman visits; gestational diabetes screening; HPV DNA testing; sexually transmitted infection counseling; HIV screening and counseling; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies and counseling; and domestic violence screening and counseling. For more information go to: https://www.healthcare.gov/preventive-care-women/

    NOTE: The Preventative care services listed above are recommended services, not mandated services. It is up to the provider of care to determine which services to provide based on your age, gender, overall health status, personal health history and your current health condition.

42. **Prosthetics –** The purchase, fitting, and repair of prosthetic appliances. Covered prosthetics include artificial arms, legs and accessories, and artificial eyes. To comply with the Women's Health and Cancer Rights Act, coverage also includes post-mastectomy breast prostheses.

43. **Radiation Therapy –** Radium and radioactive isotope therapy.

44. **Residential Treatment Facility** – A live-in health care facility providing therapy for substance use disorder, mental illness, or other behavioral problems.

    NOTE: Therapeutic Boarding Schools are not covered.

45. **Respiratory Therapy –** Professional services of a licensed respiratory or inhalation therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

46. **Routine Patient Costs for Participation in an Approved Clinical Trial –** Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Covered Person is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, 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.
    - the U.S. Department of Veterans Affairs; or
    - an institutional review board of an institution in Nevada that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and the research institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

    Coverage will not be provided for:

    - the cost of an investigational new drug or device that is not approved for any indication by the
    - U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
    - The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
    - the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
    - a cost associated with managing an Approved Clinical Trial.
    - the cost of a health care service that is specifically excluded by the Plan; or
    - services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

47. **Second (& Third) Surgical Opinion –** A second surgical opinion consultation following a surgeon's recommendation for Surgery. The Physician, rendering the second opinion regarding the Medical Necessity of a proposed Surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual Surgery.

    A third opinion consultation will also be covered if the second opinion does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual Surgery.

48. **Skilled Nursing Facility –** Inpatient care in Skilled Nursing Facility, but only when the admission to the facility or center is Medically Necessary, is in lieu of Inpatient care at a hospital, and:

    - The condition requiring Skilled Nursing Facility admission is the same condition as necessitated a prior Hospital confinement.
    - The Skilled Nursing Facility admission occurs immediately following discharge from such prior confinement.
    - The attending Physician certifies the need for Skilled Nursing Facility care seven (7) days following admission and for every seven (7) days of confinement thereafter.

49. **Speech Therapy –** Short-term active, progressive Speech Therapy performed by a licensed or duly qualified therapist as ordered by a Physician. Speech Therapy to restore speech to a person who has lost existing speech function as a result of disease, injury or surgery, such as seizure disorder, CVA or stroke, otitis media, brain injury, hearing loss, Parkinson's disease and paralysis of the vocal cord or larynx, carcinoma of the larynx, trachea, pharynx, lip, head, neck, and dysphasia.

    NOTE: Speech Therapy is not covered for non-organic/functional speech and language disorders such as lisping, stuttering and stammering, or speech and language problems that result from non-curable developmental disorders such as developmental delay, mental retardation, Down's Syndrome and autism. Maintenance therapy is not covered. Maintenance therapy begins when the therapeutic goals of a treatment plan have been met, and no further functional progress is expected.

50. **Spinal Manipulation –** see "Chiropractic-type Care / Spinal Manipulation"

51. **Sterilization Procedures –** A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female), to the extent required by the Patient Protection and Affordable Care Act (PPACA).

    NOTE: Reconstruction (reversal) of a prior elective sterilization procedure is not covered.

52. **Substance Use Disorder**- Inpatient and Outpatient treatment of substance use disorder including detoxification services.

    For Plan purposes, "substance use disorder" is physical and/or psychological dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

53. **TMJ / Jaw Joint Treatment –** Non-dental treatment of jaw joint problems, including temporomandibular joint syndrome, cranio-mandibular disorders or other conditions of the joint linking the jawbone and skull and the complex of muscles, nerves and other tissues related to that joint.

    NOTE: Plan coverage does not include methods of treatment which are recognized as dental procedures (e.g., extraction of teeth and the application of orthodontic braces – see **Eligible Dental Expenses**).

54. **Transplant-Related Expenses** (Human Tissue) – Eligible Expenses for a non-investigative and non-experimental organ or tissue transplant for:

    - a Covered Person who is the transplant recipient.
    - a Covered Person who is an organ donor. However, Plan benefits will be reduced by any amounts paid or payable by the recipient's coverage; and
    - an organ or tissue donor who is not a Covered Person when the recipient is a Covered Person. However, Plan benefits will be reduced by any amount paid or payable by the donor's own coverage.

    In addition to other Eligible Expenses as listed in this section, eligible transplant-related expenses will include those for organ procurement and/or organ and storage costs.

NOTE: Xenographic (cross species) transplants are not covered, except for heart valves.

55. **Urgent Care Facility –** see Definitions

MEDICAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for:

1. **Air Purification Units, Etc. –** Air conditioners, air-purification units, humidifiers and electric heating units.

2. **Alternative Medicine / Complementary Health Care Services –** Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.

   Expenses for prayer, religious healing, or spiritual healing, except for services provided by a Christian Science Practitioner.

   Expenses for naturopathic, naprapathic or homeopathic treatment or supplies.

3. **Biofeedback –** Biofeedback, recreational, or educational therapy, or other forms of self-care or self- help training or any related diagnostic testing.

4. **Complications of a Non-Covered Service –** Expenses for care, services or treatment required as a result of complications from a treatment or service not covered under this Plan.

5. **Cosmetic & Reconstructive Surgery, Etc. –** Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal, but which may be considered unpleasing or unsightly. Exclusions include but are not limited to surgery for sagging or extra skin, abdominoplasty, blepharoplasty, liposuction, rhinoplasty, epikeratophakia surgery, any augmentation or reduction procedures or correction of facial or breast asymmetry (except as defined below), treatment of male-pattern baldness or hair treatment, keloid scar or other scar revision therapy, any procedures utilizing an implant which cannot be expected to substantially alter physiologic functions, earring injuries and/or earlobe repair. Complications resulting from excluded cosmetic surgery or medical procedures are not covered. Psychological factors (for example, for self-image, difficult social or peer relations) do not constitute a physical bodily function or Medical Necessity.

   The following are not subject to this exclusion:

   - Services necessitated by an Accidental Injury or Sickness.
     - coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and treatment of physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient.
     - surgery which is necessary to correct a congenital abnormality in a covered Dependent child; and
     - removal of a mastectomy-related prosthesis only if Medically Necessary due to leakage.

6. **Custodial & Maintenance Care –** Care or confinement primarily for the purpose of meeting personal needs (bathing, walking, companionship care, homemaker services, etc.) which could be rendered at home or by persons without professional skills or training.

   Services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him to live outside of an institution.

7. **Dental Care –** Dental care including, but not limited to: treatment to the teeth, extraction of teeth, treatment of dental abscesses or granulomas, treatment of gingival tissues (other than for tumors), dental exams, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, any other dental product or service customarily provided by a dentist, treatment to the gums, treatment of pain or infection known or thought to be due to dental causes and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthoses or prostheses, and replacement of metal dental fillings. However, this exclusion will not apply to the following dental/oral-related care:

    - services of a dentist (DDS or DMD) for treatment and repair of a fractured or dislocated jaw or sound natural teeth damaged in an Accidental Injury, provided such repair is performed within twelve (12) months following the injury and while the person is covered hereunder.
    - facility fees and anesthesia associated with Medically Necessary dental services if the Utilization Management Program determines that hospitalization is Medically Necessary to safeguard the health of the patient during the performance of dental services, but only when:
        - The patient is a child under age seven (7) and has been diagnosed with extensive dental decay substantiated by X-rays and narrative provided by the treating dentist; or
        - the patient has a documented illness, such as hemophilia or prior tissue or organ transplant requiring a Hospital environment to monitor vital signs; or
        - the patient has a documented mental or physical impairment requiring general anesthesia in a Hospital setting for the safety of the patient.

    Charges by the dentist or any assistant dental provider are <u>not</u> covered.

8. **Diagnostic Hospital Admissions –** Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

9. **Ecological or Environmental Medicine –** Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin which are not specifically approved by the FDA as effective for treatment.

10. **Educational or Vocational Testing or Training –** Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation.

    Training of a Covered Person for the development of skills needed to cope with an Accidental Injury or Sickness, except as may be expressly included.

11. **Exercise Equipment / Health Clubs –** Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletics, or similar clubs or programs.

12. **Fertility and Infertility Services –** Expenses for the treatment of infertility, along with services to induce Pregnancy (and complications thereof), including but not limited to services, prescription drugs, procedures or devices to achieve fertility, in-vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, zygote transfer, surrogate parenting, donor egg/semen, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses and reversal of sterilization procedures.

    NOTE: This exclusion does not apply to testing that is performed to determine a diagnosis for infertility (i.e., to determine the cause for infertility).

13. **Foot Care, Routine –** Routine and non-surgical foot care services and supplies including, but not limited to:

    - trimming or treatment of toenails.
    - foot massage.
    - treatment of corn, calluses, metatarsalgia or bunions.
    - treatment of weak, strained, flat, unstable or unbalanced feet.

    NOTE: This exclusion does not apply to orthopedic braces, orthopedic shoes, custom made foot orthotics, or Medically Necessary treatment of the feet (e.g., the removal of nail roots, other podiatry surgeries, or foot care services necessary due to a diabetes & metabolic or peripheral-vascular disease).

14. **Gender Reassignment** – Surgery, services and supplies when the criteria required under **Gender Reassignment,** listed in the **Eligible Medical Expenses** section, is not met. Procedures that may be performed as a component of a gender reassignment as cosmetic (not an all-inclusive list) will not be covered: abdominoplasty, blepharoplasty brow lift, calf implants, cheek/malar implants, chin/nose implants, collagen injections, construction of a clitoral hood, drugs for hair loss or growth, forehead lift, hair removal hair transplantation, lip reduction, liposuction, mastopexy, neck tightening, pectoral implants, removal of redundant skin, rhinoplasty, voice therapy/voice lessons.

15. **Genetic Counseling and Testing –** Expenses for genetic tests, including obtaining a specimen and laboratory analysis to detect or evaluate chromosomal abnormalities, or genetically transmitted characteristics, including:

    - **Counseling**: intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents; and
    - **Testing**: prenatal genetic testing intended to determine if a fetus has chromosomal abnormalities that indicate the presence of a genetic disease or disorder, except that payment is made for fluid or tissue samples obtained through amniocentesis, chorionic villus sampling (CVS), fetoscopy and alphafetoprotein (AFP) analysis, Early Screen for Down Syndrome, Trisomy 18 and Trisomy 13, and cystic fibrosis in pregnant women, but only if the procedure is **Medically Necessary** as determined by the physician.

16. **Hair Replacement –** Wig, hairpiece and hair replacement of nonproductive hair follicles with productive follicles from another area of the scalp or body for treatment of alopecia (baldness), or any other surgeries, treatments, drugs, services or supplies relating to baldness or hair loss. A $500.00 wig allowance is allowed only during cancer treatments.

17. **Hearing Aids & Related Examinations –** Hearing examinations, hearing aids and the fitting and repair of hearing aids.

18. **Hypnotherapy –** Treatment by hypnotism.

19. **Learning & Behavioral Disorders –** Except as noted, treatment for learning or behavioral disorders, mental retardation, or autism.

    NOTE: See “Attention Deficit Disorders (ADD & ADHD)” and “Behavioral Health Care” in the list of **Eligible Medical Expenses** for coverage information.

20. **Maintenance Care –** see “**Custodial & Maintenance Care”**

21. **Massage Therapy –** Massage therapy, except when performed by a Physician.

Medical Prescription Drugs – Claims for medical drugs anticipated to cost over $500 per dose may be subject to medical necessity review. Medical Prescription drugs with anticipated costs over $1,000 require prior authorization. For a list of medical drugs that require prior authorization or that are not covered, please refer to your Plan website at VytlOneMembers.com

22. . See the **Prescription Drugs** section for retail pharmacy drugs.
23. **Modifications of Homes or Vehicles –** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Person, including without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert systems, etc.).
24. **Nicotine Addiction –** Nicotine withdrawal programs, facilities, drugs or supplies except to the extent required by the Patient Protection and Affordable Care Act. See **Prescription Drug Coverage**.
25. **Non-Prescription Drugs** – Drugs for use outside of a hospital or other Inpatient facility which can be purchased over the counter and without a Physician's written prescription – except as may be included in the prescription coverage of the Plan or to the extent required by the Patient Protection and Affordable Care Act. Drugs for which there is a non-prescription equivalent available.
26. **Not Medically Necessary / Not Physician Prescribed –** Services for an illness, sickness, injury or condition which are not deemed Medically Necessary by the Plan, even when ordered by a Physician or other covered provider.
27. **Over-the-Counter Supplies –** Supplies that can be obtained without a Physician's prescription are not covered. Such supplies include but are not limited to ace bandages, band-aids, ankle supports, wrist supports, cotton balls, Neosporin, rubbing alcohol, latex gloves, Vaseline, toothetts, instant hot/cold packs, tourniquets, cleansing towelettes, thermometers, and pant liners/disposable underpads.
28. **Penile Implants –** see "Sex-Related Disorders"
29. **Personal Comfort or Convenience Items –** Services or supplies that are primarily and customarily used for non-medical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) vacuum cleaners, (2) motorized transportation equipment or escalators, (3) waterbeds or non-hospital adjustable beds, (4) hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (9) food liquidizers, or (10) comfort or convenience items while hospitalized.
30. **Prior Coverages –** Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this Benefit Document replaces, to the extent not also covered under the Plan pursuant to the terms of this Benefit Document.
31. **Preventive, Routine or Wellness Care –** Routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury or Pregnancy, except as may be specifically included in the **Medical Benefit Summary** or **Preventative** and **Wellness Services** under **Eligible Medical Expenses.**
32. **Rehabilitation Therapy** (Inpatient or Outpatient) – Services provided on an Inpatient or Outpatient basis for the following:

    - expenses for education, job training, vocational rehabilitation, and/or special education for sign language.
    - expenses for massage therapy, rolfing and related services.
    - expenses incurred at an Inpatient rehabilitation facility for any Inpatient care provided to an individual who is unconscious, comatose or in the judgment of the Contract Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including but not limited to coma stimulation programs and services.
    - expenses for maintenance rehabilitation.
    - expenses for speech therapy for functional purposes including but not limited to stuttering,

- stammering and conditions of psychoneurotic origin, or for childhood developmental speech delays and disorders.
- expenses for treatment of delays in childhood speech development, unless as a direct result of an injury, surgery or the result of a covered treatment.

33. **Self-Procured Services –** Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, which are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses**.

34. **Sex-Related Disorders –** Sexual dysfunctions or inadequacies. Excluded services and supplies include, but are not limited to therapy or counseling, medications, implants, hormone therapy, surgery, and other medical or psychiatric treatment.

    NOTE: This exclusion will not apply to implants, services or supplies that are authorized by the Utilization Management Organization as Medically Necessary.

35. **Surrogate Expenses –** Prenatal services that are not medically necessaryfor the health and life of the mother and/or fetus, including, but not limited to.

    - childbirth education classes.
    - epidemiological and predictive genetic screening, except genetic evaluations for pregnancy at high risk of genetic disease.
    - amniocentesis or chorionic villi sampling, except for high-risk pregnancy; and
    - medical services for surrogate mothers.

36. **Termination of Pregnancy –** Services and supplies in connection with the performance of any induced abortion services except in the following circumstances in accordance with the Hyde Amendment: (a) in the professional judgment of the pregnant woman's attending physician, the abortion is necessary to save the pregnant woman's life; or (b) the pregnancy is the result of rape or incest. Medical complications resulting from an abortion are covered. Treatment of a miscarriage/spontaneous abortion (occurring from natural causes) is covered.

37. **Vision Care –** Eye examinations for the purpose of prescribing corrective lenses.

    Vision supplies (eyeglasses or contact lenses, etc.) or their fitting, replacement, repair or adjustment. Orthoptics, vision therapy, vision perception training, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy or Lasik surgery.

38. **Vitamins or Dietary Supplements –** Prescription or non-prescription organic substances used for nutritional purposes, vitamins or vitamin therapy except as required by the Patient Protection and Affordable Care Act.

39. **Vocational Testing or Training –** Vocational testing, evaluation, counseling or training.

40. **Weight Control** – Services or supplies for obesity, weight reduction or dietary control, except for Nutritional Counseling or Bariatric Surgery to the extent included in the list of **Eligible Medical Expenses.** Prescription or non-prescription weight management drugs are also not covered. Bariatric Surgery must be authorized by the **Utilization Management Program**

PRESCRIPTION DRUG PROGRAM

Prescription Drug Benefits are administered through VytlOne. Pharmacy Customer Service is available 24 hours a day, 7 days a week at the number found on the back of your ID Card for assistance with your Prescription Drug coverage. To fill your prescription(s), use your Health Plan Identification Card at participating network pharmacies. You can obtain additional information regarding covered medications, limits, and over-the- counter drugs by going to the VytlOne website at VytlOneMembers.com.

Definitions
The following definitions apply to this Covered Prescription Drug Benefits Section:

Brand Name Drug is a drug that has a trade name and is protected by patent, meaning it can only be manufactured and produced by the company holding the patent. Brand name drugs may require step therapy or prior authorization. If a brand name drug has a generic equivalent, a brand-generic charge will apply.

Designated pharmacy means you must use the pharmacy designated by the Health Plan for that particular pharmacy benefit to apply.

Formulary is a list of drugs available for coverage under the Retail Pharmacy Benefit. Drugs covered on the formulary may be subject to utilization management limits such as prior authorization, step therapy, quantity limits, or age limits. The term Preferred Drug List (PDL) may be used interchangeably with Formulary.

Generic Drug is a drug that has the same active ingredients compared to a brand name drug with regard to its dosage, strength, quality, performance, outcome, and intended use, but is manufactured by a generic drug manufacturer after the brand name drug patent has expired.

Prescription Drug means a drug or medicine which may only be obtained by a prescription order and is approved by the US Food and Drug Administration. These products typically bear the legend “Caution, Federal Law prohibits dispensing without a prescription”.

Prescription Order means a written, electronic, or oral order for a medication or device Prescription Drug issued by a licensed prescriber within the scope of his or her practice to be administered to an individual.

Prior Authorization (PA) is a process used by health plans to ensure that drug benefits are administered as designed, that members receive medications that are safe and effective for the condition being treated, and that the medications used have the greatest value. Prior authorizations require the prescriber to receive pre- approval for prescribing a particular medication in order for the drug to be covered by the health plan benefit. The Pharmacy & Therapeutics (P&T) Committee establishes the PA criteria.

Quantity Limits (QL) is a limitation that is placed on daily dose, day’s supply, or maximum quantity over time. Quantity limits help ensure FDA-approved doses or durations are not exceeded for the safety of the member.

Specialty Drugs are high risk, high-cost drugs that are used to treat complex conditions that may require special handling and administration. Specialty drugs generally require prior authorization and are limited to a 30-day supply. Specialty drugs must be filled through the Plan designated specialty pharmacy.

Step Therapy (ST) is a process designed to assure that first line drugs which have been proven safe and effective, and that demonstrate greater value are used before second line alternatives are considered.

Prescription Drug Coverage

Covered prescription drugs must be medically necessary and prescribed by a licensed provider and purchased at a network pharmacy. Out of network pharmacy claims for medical emergencies may be considered. Call Pharmacy Customer Service with questions.

The Plan has the discretion to determine the place of service for required medication therapies, i.e. provided in the home versus in an infusion center, etc. In addition, The Plan will determine if a prescription drug is covered under medical or retail pharmacy.

The amount you will pay for your prescription drugs is shown in your Outline of Coverage (OOC). Your responsibility will be based on the type of drug (generic, brand, or specialty) and what tier the drug is in.

Your preferred drug/formulary list of covered drugs has four prescription tiers. These drug tiers determine your out-of-pocket responsibility and correspond to the copays and/or coinsurance shown on your outline of coverage. In most cases, the prescription drugs on the lower tiers will cost less.

- Tier 1 – Preferred Generic Drugs
- Tier 2 – Preferred Brand Drugs and Non-Preferred Generic Drugs
- Tier 3 – Non-Preferred Brand Drugs
- Tier 4 – Specialty Drugs

Using your Prescription Drug Benefits

When you incur expenses for prescription drugs purchased from a duly licensed pharmacy pursuant to a prescription order, prescription drug benefits will be provided, as follows:

- When you use your Health Plan Identification Card at a Participating Network Pharmacy, you will be required to pay the applicable Deductible, Copay, or Coinsurance amounts specified in the Outline of Coverage (OCC) at the time of purchase.
- When you do not use your Health Plan Identification Card, you will be required to pay the entire cost of the prescription drug. You can submit a paper claim to VytlOne within 365 days of fill date for reimbursement of eligible expenses, not to exceed the amount the Plan would have paid a Participating Pharmacy if you had used your Health Plan Identification Card. Claims are denied if submitted more than one year after the services were provided.
- If you fill a prescription order using an Out-of-Network Pharmacy you will be required to paythe entire cost of the prescription drug, unless it is related to a medical emergency.
  You are able to fill a 30 day supply at any In-Network Pharmacy. The Plan uses a Nationwide Network of Pharmacies. You can locate a network pharmacy at VytlOneMembers.com.You are also able to fill a 90 day supply on certain medications through the Designated Mail Order program and at network
  pharmacies. Contact Pharmacy Customer Service at the number found on the back of your ID Card to see if your drug is eligible for the mail order or 90 day at Retail program.

Prescription Drugs with Enhanced Benefits

Certain prescription drugs are considered preventive under the Affordable Care Act (ACA). ACA preventive drugs are covered at 100 percent by the Plan (no patient responsibility); although limits may apply. Drugs available under this benefit are listed as PREV on the Formulary.

Prescription Drug Limits & Requirements

Age

Some prescription drugs have a minimum or maximum age limit requirement under the Plan. Only members within those limits are able to fill those prescription drugs.

Brand-Generic Charge (Ancillary Charge)

A Brand-Generic Charge is applied to your cost if you receive a brand name prescription drug, regardless of reason or medical necessity, if your provider prescribes a brand name drug when a generic is available. A Brand-Generic Charge is the difference between the cost of the generic and the cost of the brand name prescription drug. This charge is in addition to the regular cost sharing outlined in your benefits summary. The Brand-Generic Charge does not apply towards Deductibles or Out-of-Pocket Maximum.

Damaged/Lost/Stolen

Prescription replacements are not covered by the plan. The members will have access to network discounts, but the cost of replacement will be member responsibility. If a medication is destroyed in a fire or stolen, the plan will review for replacement only when accompanied by a police/fire report and if the provider is willing to write a new prescription. In the event a replacement is approved, it will be limited to one 30-day incident per year.

Insulin Prescription Pricing Caps
For more information regarding insulin prescription pricing caps please refer to the formulary. The formulary can be found at: VytlOneMembers.com.

Mail Order
Mail order may be available when there is when a 90-day supply of a generic or brand name prescription drug (Tier 1, 2, and 3) is mailed directly to you through a designated Mail Order Pharmacy. Not all prescription drugs are available through Mail Order. Contact Pharmacy Customer Service at the number listed on the back of your ID card for more information or to get started on the Mail Order program.

Non-Formulary (not covered) or Exception Requests for Prescription Drugs
For prescription drugs that are not covered by the Plan (non-formulary), you or your provider can submit an exception request. Your provider will be required to complete a formulary exception form and provide clinical documentation to show why this prescription drug is needed/required for treatment of your disease state or medical condition. A letter of medical necessity is also recommended. Your provider should also include in the letter your diagnosis and previous therapies that have been tried and failed. If an exception request approval is not received or the prescription drug is filled prior to approval, the cost of the prescription drug will be full member responsibility. Contact Pharmacy Customer Service at the number listed on the back of your ID card for more information.

Off-Label Use of Prescription Drugs
The FDA requires that prescription drugs used in the U.S. be safe and effective. The label information of a prescription drug outlines use for "approved" doses and specific conditions or disease states. The use of a prescription drug for a disease state or condition not listed on the label, or in a dose or therapy not listed on the label, is considered to be a "non-approved" or "off-label" use of the prescription drug. Off-label use of a prescription drug is not covered unless it meets the Plan’s off-label use policy. A Prior Authorization is required when a prescription drug is used outside of its FDA indication, dosage, or treatment. Coverage will be reviewed under the off-label use policy and subject to the same conditions and limitations as any other prescription drug. Therapies deemed investigational or experimental are not a covered benefit.

Prior Authorization (PA)
To ensure appropriate utilization, some prescription drugs and all specialty drugs require Prior Authorization to be eligible for coverage under the prescription drug benefit. In addition, prescription drugs with anticipated costs over $2,000 at retail/$4,000 at mail order require prior authorization. Your provider will be required to complete a PA form and provide clinical documentation to show why this prescription drug is needed for treatment of your disease state or medical condition. A letter of medical necessity is also recommended. Your provider should also include your diagnosis and previous therapies that have failed in the letter. If a PA is not received or if the prescription drug is filled prior to approval, the cost of the prescription drug will be full member responsibility. PAs cannot be back dated.

Quantity Limit (QL)
Quantity Limit is a program that ensures members do not receive a prescription for a quantity that exceeds recommended Plan or safety limits. Limits are set because some prescription drugs have the potential to be abused, misused, shared, or have a manufacturer’s limit on the recommended maximum dose. Quantity limits are based on FDA approved dosing, current medical practices, evidence-based clinical guidelines, and peer-reviewed medical literature related to a particular prescription drug. Prior Authorization is required for any quantities that exceed Plan limits.

Specialty Pharmacy

The Plan requires that all prescription drugs noted as Specialty must be filled through the Plan's designated Specialty Pharmacies. These drugs are usually listed on Tier 4, but certain generics specialty products may be placed in a lower tier but still be considered specialty.

Step Therapy (ST)
Step Therapy is a program for prescription drugs that are taken on a regular basis to treat an ongoing medical condition. The program is developed around effectiveness, safety, and value. In ST, the covered prescription drugs are arranged in a series of "steps". The program typically starts with generic prescription drugs as the "first step." These generics are rigorously tested and approved by the FDA and allow you to have safe, effective treatment with prescription drug that is more affordable. More expensive brand-name prescription drugs are usually considered in the "second step". Step Therapy is developed under the guidance and direction of the P&T Committee. They review the most current research on thousands of drugs tested and approved by the FDA for safety and efficacy. The first time you submit a prescription that is not for a first-step drug, your pharmacist will receive a message to tell you that the Plan requires ST. This means if you don't want to pay full price for your prescription drug, your doctor needs to write a new prescription for a "first-step" drug. With ST, if you've already tried and failed the "first-step" drug, can't take the "first-step" drug (because of an allergy, etc.), and/or your provider can show medical necessity for the second step products, your provider can submit a request for Prior Authorization review.

Therapeutic Interchange (TI)
Therapeutic interchange is the practice of replacing, with your physician's approval, a prescription drug originally prescribed with a chemically different but therapeutically equivalent prescription drug. Prescription drugs used in therapeutic interchange programs are expected to produce similar levels of effectiveness and results. Therapeutic interchange programs are based on scientific evidence. These programs are developed under the guidance of the P&T Committee. The program is designed to work along with other tools that medical professionals use to promote safe and effective drug therapy. If therapeutic interchange is required on a prescription drug, your pharmacist will receive a message to request a therapeutic interchange from your provider. If you or your provider feel the interchange is not right for you and you do not want to pay full price for your prescription, your provider can submit a request for Prior Authorization review.

Third Party Payments
Third party service providers may not waive, rebate, give, pay, or offer to waive, rebate, give, or pay all or part of the Insured's deductible or other out of pocket costs for prescription drugs. The plan will only accept third party payments of cost sharing from:

- A Ryan White HIV/AIDS Program
- An Indian tribe or tribal organization
- Local, state or federal government programs, including grantees directed by a government program to make payments on its behalf

The Plan will also accept third party payments from individuals such as family and friends, religious institutions and other not-for-profit organizations when all of the following criteria are met:

- The assistance is provided on the basis of the insured's financial need
- The institution/organization is not a healthcare provider
- The institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

Third party cost-sharing payments from the approved Third Parties identified above will accumulate towards Deductibles and/or Out-of-Pocket Maximum. All other Third-party payments are not allowed under The Plan and would not apply to a member's Deductible and/or Out-of-Pocket Maximum. If a financially interested third party payments of this type are identified after the fact, the Plan has the right to remove from the accumulation toward the Deductible and/or Out-of-Pocket Maximum.

Prescription Drug Benefit Exclusions and Limitations

Specific medications may not be a covered benefit under The Plan. Some prescriptions drugs, though FDA approved, have failed to show meaningful effectiveness toward treating any condition, may have a suitable over-the-counter alternative, may be used solely for conditions not covered by the plan, or have significant safety concerns which outweigh the benefit of the therapy. This drug exclusions list is subject to change as new drugs become available and others are removed from the market. For a complete list of covered and non-covered medications and plan limitations, contact Pharmacy Customer Service or access the retail drug formulary through the online member pharmacy portal.

The following exclusions and limitations apply to your Prescription Drug Benefits in addition to any exclusions outlined under the medical or Plan exclusions:

- Anabolic Steroids
- Biological Sera, Blood, or Blood Plasma
- Compounded Products are limited and maynot be covered if a commercial product is available. Prior Authorization may be required.
- Diabetic infusion sets, which include: (a) a cassette; (b) needle and tubing; and (3) one insulin-pump during the warranty period. Diabetic-infusion sets, pumps and accessories for insulin pumps are covered under the Durable Medical Equipment Benefit.
- Food Supplements, Special Formulas, and Special Diets
- Homeopathic Medications
- Investigational, Experimental, Clinical Trial, or Unproven Drugs: Drugs labelled “Caution – limited by federal law to investigational use”, or experimental drugs, even if a charge is made to the individual
- Medications for Cosmetic purposes (for example, but not limited to, cosmetic hair growth and removal products)
- Medications or immunizations administered for the purpose of prevention of disease when traveling to other countries (Travel vaccines)
- Medication samples, including any corresponding administration charges, such as intravenous infusion therapy and office visits for administration
- Medication taken or administered while in an provider office or facility: (In some cases, this medication is covered under the Medical Benefits portion of the Plan.)
- Medications that cannot be self-administered
- Medications that are Not Covered on the Preferred Drug List or Formulary (non-formulary medications)
- Medications that are therapeutically the same as an over-the-counter medication
- Medications that are covered under a per diem or daily rate for a Skilled Nursing, Long-term Care, or Acute Rehab facility contract
- Medications used to treat or enhance fertility
- Medications used to treat sexual dysfunction or impotence
- Medications used to treat weight loss
- Medications whose primary purpose is to correct vision and/or improve visual acuity.
- Off-label use of medication; except as outlined in the Off-label Use Policy
- Other Party Liability: Prescription Drugs which an eligible person is entitled to receive without charge under any workers compensation, or any municipal, state, or federal program.
- Over-the-Counter Medication (OTC) or other items purchased at a pharmacy other than prescription drugs whether or not there is a prescription order for the item(s), except as required under ACA
- Pigmenting/De-pigmenting Agents, except as required to treat photosensitive conditions, such as psoriasis (considered cosmetic)
- Prescription drugs in excess of a 90-day supply
- Prescription order is in excess of the day’s supply or the Plan’s quantity limit
- Refills in excess of the number specified by the physician or any refill dispensed after one year from the physician’s original prescription order
- Testosterone pellets
- Therapeutic devices or appliances, including hypodermic needles, syringes (excluding insulin needles or syringes), support garments, and other non-medicinal substances, regardless of

intended use. (In some cases, items may be covered under the Medical Benefits portion of the Plan.)

Vitamins and Minerals, except prenatal vitamins or vitamins as required under ACA. Please note vitamins may be limited to coverage by age and specific dosing requirements.

DENTAL PLANS

CHOICE OF PPO OR NON-PPO PROVIDERS

The Plan Sponsor has contracted with Diversified Dental Services, a Dental Preferred Provider Organization (DPPO). You can access a listing of the dental providers by going to www.ddsppo.com or calling 866-270-8326 or 775-337-1180.

When obtaining dental care services, a Covered Person has a choice of using a provider who is participating in the DPPO network or any other Covered Provider of his/her choice (a Non-DPPO provider). Because DPPO providers have agreed to provide dental services at negotiated rates, when a Covered Person uses a DPPO provider, his/her out-of-pocket costs may be reduced because he/she will not be billed for expenses in excess of Usual and Customary and Reasonable or in excess of the negotiated rates.

SCHEDULE OF DENTAL BENEFITS

CALENDAR YEAR MAXIMUM BENEFITS Dependent child up to age 19 All others	Unlimited $1,500
ORTHODONTIC LIFETIME MAXIMUM	$1,000
CALENDAR YEAR DEDUCTIBLE Individual Deductible Family Maximum Deductible	 $ 75 $ 225
Individual Deductible – The Individual Calendar Year Deductible is an amount which a Covered Person must contribute toward payment of eligible dental expenses each Calendar Year. Family Maximum Deductible – If $225 in eligible dental expenses is incurred collectively by family members who are Covered Persons during a Calendar Year, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.	

ELIGIBLE DENTAL EXPENSES	**Member Pays**
Preventive Services (Deductible waived)	No Charge
Limits applicable to certain Preventive Services: • Routine oral examinations and cleanings are limited to 2 exams/cleanings per Calendar Year. • Fluoride treatment is limited to children under the age of 19 once per Calendar Year. • Sealants are limited to children under the age of 19 once per year. • Full-mouth X-rays are limited to once per 3-year period and routine bitewings are limited to 2 sets per Calendar Year.	
Basic Services	20% after Deductible
Major Services	50% after Deductible
Orthodontic Services	50% after Deductible

DENTAL PRE-TREATMENT ESTIMATE

If extensive dental work is needed, the Contract Administrator recommends that a pre-treatment estimate be obtained prior to the work being performed. Emergency treatments, oral examinations including prophylaxis, and dental X-rays will be considered part of the "extensive dental work" but may be performed before the pre-treatment estimate is obtained.

A pre-treatment estimate is obtained by having the attending dentist complete a statement listing the proposed dental work and charges. The form is then submitted to the Contract Administrator for review and estimate of benefits. The Contract Administrator may require an oral exam (at Plan expense) or request X- rays or additional information during the course of its review.

A pre-treatment estimate serves two purposes. First, it gives the patient and the dentist a good idea of benefit levels, maximums, limitations, etc., that might apply to the treatment program so that the patient's portion of the cost will be known and, secondly, it offers the patient and dentist an opportunity to consider other avenues of restorative care that might be equally satisfactory and less costly.

Most dentists are familiar with pre-treatment estimate procedures and the dental claim form is designed to facilitate pre-treatment estimates.

If a pre-treatment estimate is not obtained prior to the work being performed, the Contract Administrator reserves the right to determine Plan benefits as if a pre-treatment estimate had been obtained.

NOTE: A pre-treatment estimate is not a guarantee of payment. Payment of Plan benefits is subject to Plan provisions and eligibility of the patient at the time the services are actually incurred. The pre-treatment estimate is valid for ninety (90) days from the date of issue.

ELIGIBLE DENTAL EXPENSES

Eligible dental expenses are the Usual and Customary and Reasonable charges for the dental services and supplies listed below, which are: (1) incurred while a person is covered under the Plan, and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision or any Physician furnishing dental services for which he/she is licensed.

For benefit purposes, dental expenses will be deemed incurred as follows:

- for an appliance or modification of an appliance, on the date the final impression is taken.
- for a crown, inlay, onlay or gold restoration, on the date the tooth is prepared.
- for root canal therapy, on the date the pulp chamber is opened; or
- for any other service, on the date the service is rendered.

NOTE: Many dental conditions can be properly treated in more than one way. The Plan is designed to help pay for dental expenses, but not for treatment which is more expensive than necessary for good dental care. If a Covered Person chooses a more expensive course of treatment, the Plan will pay benefits equivalent to the least expensive treatment that would adequately correct the dental condition.

PREVENTIVE SERVICES

1. **Exams & Cleanings, Routine –** Routine oral examinations and routine cleaning and polishing of the teeth.
2. **Emergency –** Palliative treatment.
3. **Fluoride –** Topical application of stannous or sodium fluoride.
4. **Prophylaxis –** see "Exams & Cleanings, Routine"
5. **Sealants –** Application of sealants to the pits and fissures of the teeth, with the intent to seal the teeth and reduce the incidence of decay. Coverage is limited to application on the occlusal (biting) surface of permanent molars which are free of decay or prior restoration and to children under age 19.
6. **Space Maintainers –** Fixed and removable appliances to maintain (not change) the space left by a prematurely lost primary or "baby" tooth and to prevent abnormal movement of the surrounding teeth.
7. **X-rays, Routine –** Routine full mouth X-rays, routine bitewing X-rays and supplementary periapical X- rays as necessary. “Full mouth X-rays” means a panorex plus bitewings or fourteen (14) periapical films plus bitewings.

   NOTE: X-rays necessary for proper claims adjudication can be requested by the Plan. Periapical X- rays must be submitted for all teeth requiring crowns or teeth that are to be used as abutments for a bridge.

BASIC SERVICES

1. **Anesthesia –** General, Local Anesthesia or intravenous sedation when administered in connection with oral surgery.

   NOTE: Hypnosis and relative analgesia are not covered unless the patient is completely anesthetized to a state of unconsciousness as with a general anesthetic.

2. **Consultation**
3. **Crowns –** A crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary. The maximum allowance for a crown on a primary tooth will be the allowance for a stainless-steel crown.

   Replacement of a crown, if the existing crown is at least five (5) years old.
4. **Endodontia –** Endodontic services including but not limited to, root canal therapy (but not on a primary tooth), pulpotomy, apicoectomy and retrograde filling.
5. **Extraction –** see "Oral Surgery"
6. **Fillings, Non-Precious –** Amalgam, silicate, composite and plastic restorations, including pins to retain a filling restoration when necessary.

   Replacement of a filling if the existing restoration is at least twenty-four (24) months old.
7. **Injections –** Injection of antibiotic drugs.
8. **Inlays, Onlays & Gold Restorations –** An inlay, onlay or gold restoration when a tooth cannot be satisfactorily restored with a less costly filling (amalgam, etc.) restoration.

   Replacement of an inlay, onlay or gold restoration, if the existing restoration is at least five (5) years old.
9. **Mouth Guards**
10. **Nitrous Oxide**

11. **Oral Surgery –** Extraction of teeth, including simple extractions and surgical extractions of bone or tissue-impacted teeth. Biopsy of oral tissue (but not including laboratory costs), and other surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.
12. **Palliatives –** Emergency treatment for the relief of dental pain.
13. **Periodontal –** Periodontal scaling and root planning and surgical procedures (i.e., gingivectomy, osseous surgery and mucogingival surgery). Any allowance for periodontal surgery includes postoperative care for six (6) months following the surgery.
14. **Temporary Crowns**
15. **Visits, Non-Routine –** Office visits other than those covered as "Preventive Services."
16. **X-Rays, Non-Routine –** X-rays other than those covered as "Preventive Services."

MAJOR SERVICES

1. **Implants –** Placement of an implant to replace a missing tooth.
2. **Prosthetics –** Initial placement of a full or partial denture or bridge.

   Addition of teeth to a partial denture or bridge.

   Replacement of an existing full or partial denture or bridgework, but only if the existing denture or bridgework cannot be made serviceable and is at least four (4) years old.

   NOTE: Fixed bridges are not covered for a child less than sixteen (16) years of age. An allowance will be made for a partial denture.
3. **Repairs & Adjustments –** Repair of bridgework or dentures, the relining of dentures and prosthetic adjustments.

ORTHODONTIC SERVICES

1. **Cephalometric X-rays**
2. **Orthodontic Treatment –** Installation of orthodontic appliances and adjustments.

DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated, no benefits will be payable under this Plan for:

1. **Congenital or Developmental Conditions –** Treatment of congenital (hereditary) or developmental (following birth) malformations.
2. **Cosmetic Dentistry –** Treatment rendered purely for cosmetic purposes.
3. **Customized Prosthetics –** Excess charges for precision or semi-precision attachments, overdentures, or customized prosthetics.
4. **Discoloration Treatment –** Teeth whitening or any other treatment to remove or lessen discoloration, except in connection with endodontia.
5. **Excess Care –** Services which exceed those necessary to achieve an acceptable level of dental care, as determined by the Claims Administrator in its sole discretion. If it is determined that alternative procedures, services, or courses of treatment could be (could have been) performed to correct a dental condition, Plan benefits will be limited to the least costly procedure(s) which would produce a professionally satisfactory result.

6. **Experimental Procedures –** Services which are considered experimental, or which are not approved by the American Dental Association.
7. **Grafting –** Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).
8. **Hospital Expenses**
9. **Implant Removal –** The removal of implants.
10. **Lost or Stolen Prosthetics or Appliances –** Replacement of a prosthetic or any other type of appliance which has been lost, misplaced, or stolen.
11. **Medical Expenses –** Any dental-related services to the extent to which coverage is provided under the terms of the medical benefits of this Plan.
12. **Non-Professional Care –** Services rendered by someone other than:
    - a dentist (DDS or DMD);
    - a dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist; or
    - a Physician furnishing dental services for which he/she is licensed.
13. **Oral Hygiene Instruction & Supplies, Etc. –** Dietary or nutritional counseling or related supplies, personal oral hygiene instruction or plaque control. Oral hygiene supplies including but not limited to: toothpaste, toothbrushes, waterpiks, and mouthwashes.
14. **Orthognathic Surgery –** Surgery to correct a receding or protruding jaw.
15. **Personalization or Characterization of Dentures –** Excess charges for the personalization or characterization of dentures.
16. **Prescription Drugs –** see the **Prescription Drugs** section
17. **Replanted / Transplanted Teeth –** Restorations on replanted or transplanted teeth.
18. **Splinting –** Appliances or restorations for splinting teeth.

(See also **General Exclusions** section)

GENERAL EXCLUSIONS

The following exclusions apply to all health benefits, and no benefits will be payable for:

1. **Alcohol –** Charges for care, supplies, treatment, and/or services that arise from a Covered Person taking part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Use Disorder treatment as specified in this Plan, if applicable. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

2. **Claims Edit –** Charges identified as not following the Medicare Guidelines bundling and unbundling of CPT code combinations, gender-appropriate procedure codes, appropriateness of multiple office visits.

3. **Court-Ordered Care, Confinement or Treatment –** Any care, confinement or treatment of a Covered Person in a public or private institution as the result of a court order, unless the confinement would have been covered in the absence of the court order.

4. **Drugs in Testing Phases –** Medicines or drugs which are in the Food and Drug Administration Phases I, II, or III testing, drugs which are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

   Except as specifically authorized by the United States Food and Drug Administration, any treatment using dimethyl sulfoxide (DMSO), laetrile or gerovital.

5. **Excess Charges –** Charges for care, supplies, treatment, and/or services that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

6. **Experimental / Investigational Treatment –** Charges for care, supplies, treatment, and/or services that are Experimental or Investigational.

7. **Forms Completion –** Charges made for the completion of claim forms or for providing supplemental information.

8. **Government-Operated Facilities –** Services furnished to the Covered Person in any veteran's hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments. See NOTE.

   NOTE: This exclusion does not apply to treatment of non-service-related disabilities or for Inpatient care provided in a military or other Federal government hospital to Dependents of active duty armed service personnel, or armed service retirees and their Dependents. This exclusion does not apply where otherwise prohibited by law.

9. **Illegal Acts –** Charges for care, supplies, treatment, and/or services for any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions), or (c) for substance abused treatment.

10. **Late Fees, Interest, Finance Charges**

11. **Late-Filed Claims –** Claims which are not filed with the Contract Administrator for handling within one (1) year from the date of service. See **Claims Procedures** section for additional information.

12. **Military Service –** Conditions that are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

13. **Missed Appointments –** Expenses incurred for failure to keep a scheduled appointment.

14. **No Charge / No Legal Requirement to Pay –** Services for which no charge is made or for which a Covered Person is not required to pay or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a "secondary" coverage, this exclusion will apply to those amounts which a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

    NOTE: This exclusion does not apply to any benefit or coverage which is available through the Medical Assistance Act (Medicaid).

15. **Not Listed Services or Supplies –** Any services, care or supplies which are not specifically listed in the Benefit Document as Eligible Expenses will not be covered unless the expense is substantiated and determined to be Medically Necessary and is approved for coverage by the Contract Administrator.

16. **Other Coverage –** Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules.

    Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

17. **Outside United States –** Charges incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services or supplies.

18. **Postage, Shipping, Handling Charges, Etc. –** Any postage, shipping or handling charges which may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

19. **Prior Coverages –** Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this Benefit Document replaces, to the extent such benefits are not covered under the Plan pursuant to this Benefit Document.

20. **Prior to Effective Date / After Termination Date –** Charges incurred prior to an individual's effective date of coverage under the Plan or after coverage is terminated, except as may be expressly stated.

21. **Relative or Resident Care –** Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

22. **Sales Tax, Etc. –** Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

23. **Self-Inflicted Injury –** Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction, except that this exclusion will not apply where such self-inflicted injury results from a documented medical condition (physical or mental), including a medical condition resulting from being the victim of an act of domestic violence (e.g., depression).

24. **Subrogation, Reimbursement, and/or Third-Party Responsibility –** Charges for care, supplies, treatment, and/or services that are of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions.
25. **War or Active Duty –** Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.
26. **Work-Related Conditions –** Any condition which is covered or subject to any workers' compensation law or federal employer compensation or liability acts, even if the Covered Person or the Employer is not in compliance therewith or has rejected or not applied for such coverage.

COORDINATION OF BENEFITS (COB)

Health care benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

DEFINITIONS

As used in this **COB** section, the following terms will be capitalized and will have the meanings indicated:

1. **Other Plan –** Any of the following that provides health care benefits or services:

   - group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured). A "closed panel plan" is a plan that, except in an emergency, provides coverage only in the form of services obtained through a panel of providers that have contracted with or are employed by the plan.
   - medical care components of group long-term care contracts, such as skilled nursing care.
   - medical benefits under group or individual automobile contracts.
   - auto insurance which is subject to a state "no-fault" automobile insurance law. A Covered Person will be presumed to have at least the minimum coverage requirement of the state of jurisdiction, whether or not such coverage is actually in force.
   - Medicare or other governmental benefits, as permitted by law.

   An "Other Plan" does not include: (1) closed panel or other individual coverage (except for group-type coverage), (2) school accident type coverage, (3) benefits for non-medical components of group long- term care policies, (4) Medicare supplement policies, (5) Medicaid policies or coverage under other governmental plans, unless permitted by law.

   NOTE: An "Other Plan" includes benefits that are actually paid or payable or benefits which would have been paid or payable if a claim had been properly made for them.

   If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

2. **This Plan –** The coverages of this Plan.

3. **Allowable Expense –** The Usual and Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the “Application to Benefit Determinations” Section, herein, this Plan’s Allowable Expenses shall in no event exceed the Other Plan’s Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made, therefore.

   In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO Provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.

   NOTE: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., pre-certification of admissions, second surgical opinion requirements, etc.) will not be considered an Allowable Expense.

4. **Claim Determination Period –** A period which commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see **EFFECT ON BENEFITS UNDER THIS PLAN**).

5. **Custodial Parent –** A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one-half of the Calendar Year without regard to any temporary visitation.

EFFECT ON BENEFITS UNDER THIS PLAN

Application to Benefit Determinations – The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

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

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

- the Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
- the rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination – For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

- A plan without a coordinating provision will always be the primary plan.
- The benefits of a plan which covers the person on whose expenses a claim is based, other than as a Dependent, shall be determined before the benefits of a plan which covers such person as a Dependent.
- if the person for whom a claim is made is a Dependent Child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    - When the parents are separated or divorced, and the parent with the custody of the Child has not remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a Dependent of the parent without custody; or
    - when the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a Dependent of the stepparent, and the benefits of a plan which covers that Child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a Dependent of the parent without custody.

Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the Child as a Dependent Child; and

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses a claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

When Other Plan Does Not Contain a COB Provision – If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

When Other Plan Contains a COB Provision – When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

NOTE: The determination of This Plan's "normal liability" will be made for an entire Claim Determination Period (i.e. Calendar Year). If this Plan is "secondary", the difference between the benefit payments that This Plan would have paid had it been the primary plan and the benefit payments that it actually pays as a secondary plan is recorded as a "benefit reserve" for the Covered Person and will be used to pay Allowable Expenses not otherwise paid during the balance of the Claim Determination Period. At the end of the applicable Claim Determination Period, the benefit reserve returns to zero.

ORDER OF BENEFIT DETERMINATION RULES

Under Order of Benefit Determination Rules, whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules, in the order specified below.

Medicare as an "Other Plan" – Medicare will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part A and Part B benefits that would have been paid or payable, regardless of whether or not the person was enrolled for such benefits.

Active vs. Inactive Employee – The plan that covers the Claimant as an employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired is primary. 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 is ignored.

Continuation Coverage (COBRA) Enrollee – If a Claimant is a COBRA enrollee under This Plan, an Other Plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and This Plan is secondary. 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 is ignored.

Longer vs. Shorter Length of Coverage – If none of the above rules establish which plan is primary, the benefits of the plan which has covered the Claimant for the longer period of time will be determined before those of the plan which has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information – For the purpose of enforcing or determining the applicability of the terms of this **COB** section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

Facility of Payment – A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

Right of Recovery – In accordance with the **Recovery of Payments** provision, whenever payments have been made by This Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Covered Person or his or her Dependents. Please see the **Recovery of Payments** provision for more details.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits, the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

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

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage,

The Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery, will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over Plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available, any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
7. To not settle or release, without the prior consent of the Plan, any claim that the Participant may have against any responsible party or Coverage.
8. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(s) is a minor, as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this Article is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this Article and/or the Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements – Employees

An individual eligible to participate in the Plan as an "Employee" includes:

- an Employee classified as full-time or part-time and regularly scheduled to work at least twenty (20) hours per week.
- **Variable Hour Employees** – an Employee for whom CTHS cannot in good faith determine whether the individual's hours are expected to average at least 30 hours per week at hire. Those Variable Hour Employees who average at least 30 hours per week during the Initial Measurement Period (IMP) or Standard Measurement Period (SMP) are eligible for benefits during the subsequent Stability Period (SP), subject to an Administrative Period (AP), if any.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

NOTE: An eligible Employee (age sixty-five (65) and over) may elect or reject coverage under this Plan for the Employee and his or her eligible Dependents (including a spouse aged sixty-five (65) or older). If such eligible Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Effective Date – Employees

An eligible Employee's coverage is effective, subject to timely enrollment, on the first (1st) of the month following thirty-one (31) days of active continuous employment.

Eligibility Requirements – Dependents

An eligible Dependent of an Employee is:

- a legally married spouse. A "spouse" will mean a person of the opposite sex or same-sex who is not eligible for coverage under their own Employer-sponsored health, dental, or vision plan. "Legally married" means a legal union as defined by the applicable state law at the time and location that the marriage was entered into. In no instance will an eligible spouse include a common law spouse.
- a child who is under age 26 (i.e., through age 25). The child need not: (1) reside with the Employee or any other person, (2) be a student, (3) be a tax-code dependent of the Employee or financially dependent on the Employee or any other person, (4) be unmarried, or (5) be unemployed. For these purposes a "child" will include:
    - a natural child.
    - a stepchild.
    - a child placed under the court-appointed legal guardianship of the Employee.
    - a child who is adopted by the Employee or placed with him for adoption prior to age 19. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption, and the legal process must have begun. Placement ends when the legal support obligation ends.
    - Notwithstanding any residency or main support and care requirements, a child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child

Support Order which the Contract Administrator determines to be a Qualified Medical Child Support Order (QMSCO) in accordance with its written procedures (which are incorporated herein by reference and which can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of state law.

NOTE: An eligible Dependent does not include:

- a spouse who is eligible for medical coverage through their own Employer, regardless of if they elect coverage or not;
- a spouse following legal separation or a final decree of dissolution or divorce.
- any person who is on active duty in a military service, to the extent permitted by law.
- any person who is eligible and has enrolled as an Employee under the Plan.
- any person who is covered as a Dependent of another Employee under the Plan.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Proof of Dependent Status

Specific documentation to substantiate Dependent status may be requested at any time and may include any of the following:

- Marriage – a copy of the certified marriage certificate.
- Birth – a copy of the certified birth certificate.
- Adoption or placement for adoption – a copy of the court order signed by the judge. Final adoption decree and/or birth record must be submitted to the CTHS Human Resources office within thirty-one (31) days of issuance.
- Legal guardianship – a copy of the legal guardianship court order, signed by the judge, and a copy of the certified birth certificate.

Effective Date – Dependents

A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later through marriage, adoption, placement for adoption, or birth may be enrolled within Sixty (60) days of their eligibility date and coverage will be effective on the first day of the month following enrollment (see the "Special Enrollment Rights" provision for details, as well as instances when the loss of other coverage and other circumstances can allow an eligible Dependent to be enrolled in the Plan mid-Plan Year). Otherwise, an eligible Dependent can be enrolled only in accordance with the "Open Enrollment" provision.

NOTE: In no instance will a Dependent's coverage become effective prior to the Employee's coverage effective date.

Notification of Family Status Change

It is a covered Employee's responsibility to notify CTHS Human Resources office promptly whenever he has a change in family status as described below:

- the employee has a Dependent or Dependents covered under the Plan who are no longer eligible for coverage under the Plan.
- The employee or any covered Dependent becomes eligible for Medicare's Part A, B, C and D Prescription plan.

NOTE: Failure to report a family and/or status change to the CTHS office could result in loss of contributions. A maximum of two (2) months of contributions will be reimbursed for overpayment due to non-notification of a family and/or status change.

Plan Elections and Changes

Plan elections generally remain in place for the entire plan year, provided the required contributions for coverage are received from the Employee. An Employee may not change his elected options under the Plan or Dependent coverage tier except during Open Enrollment, unless there is a Qualifying Life Event, listed below, and the change is consistent with the event.

1. Entitlement Due to Loss of Other Coverage – An eligible Employee who did not enroll himself or his eligible Dependent(s) in the Plan when previously eligible will be allowed to enroll himself or his eligible Dependent(s) in coverage under the Plan at a later date if:

    - The Employee or his Dependents were covered under another group health plan or other health insurance coverage (including Medicaid) at the time coverage was initially offered or previously available. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer.
    - the Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Administrator required such a written statement and provided the Employee with notice of the requirement and the consequences of failure to comply with the requirement.
    - the Employee or his Dependents lost the other coverage as a result of a certain event such as, but not limited to, the following:
        - loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment.
        - loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);
        - loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual.
        - loss of eligibility when an individual incurs a claim that would meet or exceed a lifetime limit on all benefits. An individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until thirty (30) days after the earliest date that a claim is denied due to the operation of the lifetime limit.
        - loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part- time workers, the part-

time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees.

- loss of eligibility when employer contributions toward the Employee's or Dependents' coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer.
- loss of eligibility when COBRA continuation coverage is exhausted; and
- the Employee requested Plan enrollment within sixty (60) days of termination of the other coverage.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application.

NOTE: For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

Loss of other coverage for failure to pay premiums on a timely basis or for cause (e.g., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes.

2. Entitlement Due to Acquiring New Dependent(s) – If a covered Employee acquires one (1) or more new eligible Dependents through marriage, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within sixty (60) days of the date the new Dependent or Dependents are acquired (the "triggering event") and Plan coverage will be effective as follows – see NOTE:

   - where Employee's marriage is the "triggering event" – the eligible spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application.
   - where birth, adoption or placement for adoption is the "triggering event" – the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within 60 days of birth.

   NOTE: For a newly acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently. If the newly acquired Dependent is a child, the spouse is also eligible to enroll. However, other Dependent children who were not enrolled when first eligible are not considered to be newly acquired and can only be enrolled in accordance with the late enrollment provisions of the Plan.

   Court or Agency Ordered Coverage – If an Employee or an Employee's spouse is required to provide coverage for a child under a Medical Child Support Order, coverage for the child shall be effective as of the date specified in such order provided that such order is qualified according to the Contract Administrator's written procedures and provided that a request for coverage is made on a form acceptable to the Contract Administrator within 60 days from the date such order is determined to be qualified. A request to enroll the child may be made by the Employee, the Employee's spouse, the child's other parent, or by a State Agency on the child's behalf.

   If the Employee is not enrolled when the Plan is presented with an MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

3. Children's Insurance Program Reauthorization Act (CHIPRA)

Loss of Medicaid or CHIP Eligibility: If the Employee's or the Employee's Dependent child(ren)'s Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, the Employee may request coverage under the Plan within sixty (60) days after Medicaid or CHIP coverage terminates.

Eligibility for State Premium Assistance: Where a State has chosen to offer premium assistance subsidies for qualified employer-sponsored benefits (see NOTE) and if the Employee or the Employee's Dependent child(ren) becomes eligible for such subsidy under Medicaid or CHIP, then the Employee may request coverage under the Plan within sixty (60) days after eligibility for the subsidy is determined.

Also, if an Employee's child(ren) become eligible for CHIP, Employee has the ability to drop the child(ren) from coverage under the Plan.

NOTE: CHIPRA allows states to elect to offer premium assistance subsidies to qualified individuals. Such subsidies are not mandated.

A "group health plan" does not include benefits provided under a health FSA or a high deductible health plan.

Open Enrollment

If an eligible Employee does not enroll in the Plan when he is first eligible to do so or if he allows coverage under the Plan to lapse, he may not enroll or re-enroll (as applicable) in the Plan until the next Open Enrollment period, which will be held annually and which coverage will be effective for the subsequent Plan Year (unless the eligible Employee experiences an event listed in the **Plan Elections and Changes** section permitting enrollment outside of the Open Enrollment period). Plan coverage will be effective on the January 1st following the end of the Open Enrollment period and will generally be effective for the entire Plan Year, unless earlier termination of the coverage occurs as explained in the **TERMINATION OF COVERAGE** section or unless an Employee may change his elections pursuant to the **Plan Elections and Changes** section.

Reinstatement

If an Employee returns to an eligible status following an approved leave of absence and elects to re- enroll himself/herself and his/her previously covered Dependents, then Plan coverage will be effective on the first day of the month in which active employment resumes. Except for Dependents acquired within sixty (60) days of the Employee's coverage effective date, Dependents not covered by the Plan before the lapse in coverage can only be enrolled during an Open Enrollment period or in accordance with the Special Enrollment Rights.

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave Employee discontinued paying his/her share of the cost of coverage causing coverage to terminate, such Employee may have coverage reinstated as if there had been no lapse (for himself/herself and any Dependents who were covered at the point contributions ceased). The Contract Administrator will have the right to require that unpaid coverage contribution costs be repaid.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active-duty service as a member of the United States armed forces will be reinstated to coverage under the Plan immediately upon returning from military service. Additional information concerning the USERRA can be obtained from the Contract Administrator.

NOTE: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements before enrolling in the Plan, even if the Employee was previously covered under the Plan immediately prior to the termination of employment.

NOTE: Benefits for any Employee or Dependent who is covered under the Plan, whose employment or coverage is terminated, and who is reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

Transfer of Coverage

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his/her eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Except as noted, such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

TERMINATION OF COVERAGE

Employee Coverage Termination

An Employee's coverage under the Plan will terminate upon the earliest of the following:

- termination of the Plan.
- termination of participation in the Plan by the Employee.
- the date the Employee begins active-duty service in the armed services of any country or organization, except for reserve duty of less than thirty (30) days. See the "Extension of Coverage During U.S. Military Service" in the **Extensions of Coverage** section for more information.
- at midnight of the last day of the period for which payment of the contributions has been made by the Employer for such Employee leaving the Employer or ceasing to be eligible, or by the Employee if not fully Employer paid.
- at midnight of the last day of the month the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section – except when coverage is extended under the terms of any **Extension of Coverage** provision.
- the date the Employee dies.

Dependent Coverage Termination

A Dependent's coverage under the Plan will terminate upon the earliest of the following:

- termination of the Plan or discontinuance of Dependent coverage under the Plan.
- termination of the coverage of the Employee.
- the Employee’s termination of the Dependent’s coverage under the Plan.
- at midnight on the last day of the month in which the Dependent ceases to meet the eligibility requirements of the Plan, except when coverage is extended under the terms of any **Extension of Coverage** provision. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee.
- the end of the period for which the Employee last made the required contribution for such coverage, if the Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage which will take effect immediately upon termination.

- (See **COBRA Continuation Coverage**) -

EXTENSION OF COVERAGE PROVISIONS

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage for a Dependent will not extend beyond the date the Employee's coverage ceases.

Extension of Coverage for Disabled Dependent Children

If an already covered Dependent child is incapable of self-sustaining employment by reason of cognitive disability, cerebral palsy, epilepsy, other neurological disorder or physical or mental disability, and:

- such conditions commenced on or before the child attained the age that would otherwise terminate his eligibility;
- the child's condition has been diagnosed by a Physician as a permanentor long-term dysfunction or condition; and
- Such child is primarily dependent upon the Employee for support and maintenance.

Then such child's status as a "Dependent" will not terminate solely by reason of his having attained the limiting age and he will continue to be considered a covered Dependent under the Plan so long as he remains in such condition and otherwise conforms to the definition of "Dependent."

The Employee must submit proof of the child's incapacity to the Contract Administrator within sixty (60) days of the child's attainment of the limiting age, and thereafter as may reasonably be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

Extensions of Coverage During Absence from Work

If an Employee goes on a qualified leave under the Family and Medical Leave Act of 1993 (FMLA), the following rules will apply. For the duration of a qualifying leave, CTHS will continue to maintain the Employee's benefits under this Plan on the same terms and conditions as though he/she were still an active Employee. However, the Employee will be responsible for continuing to pay any required premium contributions. These contributions may be taken by payroll deduction for any periods of the FMLA leave that are paid; for any periods of the FMLA leave that are unpaid, the Employee is expected to timely pay all required contributions. The Employee's coverage under the Plan will immediately cease upon expiration of FMLA leave if the Employee fails to return to work at such time, or earlier if the Contract Administrator learns that the Employee does not intend to return to work after the leave (except as otherwise provided by the FMLA). Except as otherwise provided by the FMLA, failure to return to work after the FMLA leave expires will require the Employee to reimburse CTHS for the cost of the coverage provided while on FMLA. For more information on FMLA leave, please contact CTHS, where a summary of rights under FMLA Leave may be obtained without charge.

Extension of Coverage During U.S. Military Service

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements – To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances.

If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment, and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Contract Administrator will continue coverage for the first thirty (30) days after the Employee's departure from employment due to active military service. The Contract Administrator will terminate coverage if the Employee's notice to elect continuation of coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage – The Employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the Plan continuing coverage under COBRA, the Contract Administrator will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Contract Administrator will reinstate the Employee to Plan coverage retroactive to the last day of the period for which the premium was paid. The Employee will be responsible for payment of all back premium charges owed.

Maximum Period of Coverage – The maximum period of USERRA continuation coverage is the lesser of:

- 24 months; or
- the duration of the Employee's active military service.

Reinstatement of Coverage Following Active Duty – Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions and otherwise satisfies all reemployment requirements (including any requirements regarding application for reemployment).

The Employee must generally:

- Return to employment with the Employer no later than the first full business day following completion of military service for a military leave of 30 days or less: or
- Submit an application for reemployment with the Employer within 14 days of completion of military service for a military leave of 31-180 days: or
- Submit an application for reemployment with the Employer within 90 days of completion of military service for a military leave of more than 180 days.
- When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period can be imposed on a returning Employee or his eligible Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

CLAIMS PROCEDURES

Assignment to Provider

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss.

Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

In the event the Plan fails to pay benefits to a provider in respect of a claim incurred by a Covered Person, the Employee or Covered Person will be responsible for paying the provider any amounts due for the services received.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan or to enforce rights due under the Plan or any other causes of action that he may have against the Plan or its fiduciaries.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

Types of Claims

There are three types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A “pre-service claim” is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

   A “pre-service urgent care claim” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person’s ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Covered Person’s medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

   If the Plan does not require the Covered Person to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Covered Person simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

2. Concurrent Claims. A “concurrent claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

   The Contract Administrator determines that the course of treatment should be reduced or terminated; or The Covered Person requests extension of the course of treatment beyond that which the Contract Administrator has approved.

   If the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Contract Administrator to request an extension of a course of treatment. The Covered Person simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

3. Post-service Claims A “post-service claim” is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Post-service health claims must be filed with the Contract Administrator within 1 year of the date charges for the service were incurred unless otherwise specified in the providers contract. Benefits are based upon the Plan’s provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Contract Administrator in accordance with the Plan’s procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Contract Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Contract Administrator within 45 days from receipt by the Covered Person of the request for additional information (or within 48 hours of a request for additional information for a pre-service urgent care claim). **Failure to do so may result in claims being denied or reduced.**

NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan, and the Plan should have been primary.

Timing of Claim Decisions

The Contract Administrator shall notify the Covered Person or Authorized Representative, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims: If the Covered Person or Authorized Representative has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim. If a pre-service urgent care claim is denied, the Covered Person or Authorized Representative will be notified via fax followed by written notice within three days.

   If the Covered Person or Authorized Representative has not provided all of the information needed to process the claim, then the Covered Person or Authorized Representative will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The covered person will be notified of a determination of benefits as soon as possible, but not later than 24 hours, taking into account the medical exigencies, after the earliest of:

   - The Plan’s receipt of the specified information; or
   - The end of the period afforded the Covered Person or Authorized Representative to provide the information.

2. Pre-service Non-urgent Care Claims: If the Covered Person or Authorized Representative has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested. If an extension has been requested, then notification will occur no later than the end of the 15-day extension period.

   If the Covered Person or Authorized Representative has not provided all of the information needed to process the claim, then the Covered Person or Authorized Representative will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Covered Person or Authorized Representative will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was not requested during the initial processing period), or by the date agreed to by the Contract

Administrator and the Covered Person or Authorized Representative (if additional information was requested by the Plan and timely provided by the Covered Person or Authorized Representative).

3. Concurrent Claims: Plan Notice of Reduction or Termination. If the Contract Administrator is notifying the Covered Person or Authorized Representative of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Covered Person or Authorized Representative will be notified sufficiently in advance of the reduction or termination to allow the Covered Person or Authorized Representative to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

   Request by Covered Person or Authorized Representative Involving Urgent Care. If the Contract Administrator receives a request from a Covered person to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, as long as the Covered Person or Authorized Representative makes the request at least 24 hours prior to the expiration of the previously prescribed period of time or number of treatments. If the Covered Person or Authorized Representative submits the request with less than 24 hours' notice prior to the expiration of the previously prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

   Request by Covered Person or Authorized Representative Involving Non-urgent Care. If the Contract Administrator receives a request from the Covered Person or Authorized Representative to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

4. Post-service Claims: If the Covered Person or Authorized Representative has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested. If an extension has been requested, then notification will occur no later than the end of the 15-day extension period.

   If the Covered Person or Authorized Representative has not provided all of the information needed to process the claim and additional information is requested during the initial processing period (but within 30 days of the receipt of the claim), then the Covered Person or Authorized Representative will be notified of a determination of benefits by a date agreed to by the Contract Administrator and the Covered Person or Authorized Representative, if the Covered Person or Authorized Representative timely provided all additional information requested.

Extensions

1. Pre-service Urgent Care Claims. No extensions are available in connection with pre-service urgent care claims.

2. Pre-service Non-Urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Contract Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person or Authorized Representative, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

3. Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Contract Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person or Authorized Representative, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods.

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Contract Administrator shall provide a Covered Person or Authorized Representative with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice to follow), containing the following information:

- A reference to the specific portion(s) of the Plan Document upon which a denial is based.
- Specific reason(s) for a denial.
- A description of any additional information necessary for the Covered Person or Authorized Representative to perfect the claim and an explanation of why such information is necessary.
- A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Covered Person's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.
- A statement that the Covered Person or Authorized Representative is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits.
- Any internal rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Covered Person or Authorized Representative, free of charge, upon request).
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided to the Covered Person or Authorized Representative, free of charge, upon request; and
- In a claim involving urgent care, a description of the Plan's expedited review process.

Filing an Appeal

Within 180 days of receiving notice of a claim reduction or denial, a Covered Person may appeal the adverse benefit determination, in writing, to a new decision-maker and he may submit new information (comments, documents, records, etc.) in support of his appeal. A Covered Person may not take legal action on a denied claim until he has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures**. This Plan has one (1) internal level of appeal.**

Authorized Representative

A Covered Person may designate an authorized representative to file an appeal on behalf of the Covered Person. Authorized representative is defined as "an individual who acts on behalf of an individual or under applicable law. An organization may establish procedure for determining whether an individual is authorized to act on behalf of one of its members. For urgent care decisions an organization allows a healthcare practitioner with knowledge of the members medical condition to act as the authorized representative"

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Covered Person believes the claim has been denied wrongly, the Covered Person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Covered Person with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. Covered Persons at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination.
2. Covered Persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
4. For a review that takes into account all comments, documents, records, and other information submitted by the Covered Person or Authorized Representative relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination.
5. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
6. That a Covered Person or Authorized Representative will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits in possession of the Contract Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances; and
7. In a pre-service urgent care claim, for an expedited review process pursuant to which:
8. A request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Covered Person or Authorized Representative; and
9. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Covered Person or Authorized Representative by telephone, facsimile or other available similarly expeditious method.

Requirements for Appeal

The Covered Person or Authorized Representative must file the appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within 180 days of the notification of an Adverse Benefit Determination or claim denial. For pre-service urgent care claims, if the Covered Person or Authorized Representative chooses to orally appeal, the Covered Person or Authorized Representative may telephone:

Hometown Health Plans Customer Engagement Center 775-982-5885

To file an appeal in writing, the Covered Person's appeal must be completed online or addressed as follows and mailed to:

Hometown Health Plan
Attention: Appeals
10315 Professional
Circle
Reno, NV 89521

It shall be the responsibility of the Covered Person or Authorized Representative to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the Employee/Covered Person.
- The Employee/Covered Person's plan identification number.
- All facts and theories supporting the claim for benefits. ***Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Covered Person will lose the right to raise factual arguments and theories which support this claim if the Covered Person or Authorized Representative fails to include them in the appeal.***
- *A statement in clear and concise terms of the* reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Covered Person has, which indicates that the Covered Person is entitled to benefits under the Plan.

Timing of Notification of Benefit Determination on Review

The Contract Administrator shall notify the Covered Person or Authorized Representative of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal. If the Urgent Pre-Service Care Claim decision involves a Concurrent Claim, notice of the benefit determination will be provided as soon as possible but no later than 24 hours before the prescribed time period expires or the prescribed number of treatment ends.
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
3. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods.

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Contract Administrator shall provide a Covered Person or Authorized Representative with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method (with follow-up notification in writing or electronically), and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

- The specific reason or reasons for the denial.
- Reference to the specific portion(s) of the Plan Document on which the denial is based.
- The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice.
- A statement that the Covered Person or Authorized Representative is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Covered Person or Authorized Representative upon request;
- If the Adverse Benefit Determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided free of charge upon request; and
- A statement of the Covered Person's right to bring an action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Contract Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review

If, for any reason, the Covered Person or Authorized Representative does not receive a written response to the appeal within the appropriate time period set forth above, the Covered Person or Authorized Representative may assume that the appeal has been denied. Note that: **all claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 60 days after the Plan's claim review procedures have been exhausted (including any external reviews, to the extent applicable).**

External Review

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process applies only to:

1. an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and

2. a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is the Federal external review process that is not considered expedited (as described in the “expedited external review” paragraph in this section).

Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Preliminary review. Within 5 business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

- The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.

- the Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant’s failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).

- The claimant has exhausted the Plan’s internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations.

- The claimant has provided all the information and forms required to process an external review.

Within 1 business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. 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 or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization

If the request is eligible for external review, the Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Contract Administrator to contract with, on its behalf) at least 3 IROs for assignments under the Plan and rotate claims assignments among them (or incorporate another independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

Reversal of Plan's decision

Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

Request for expedited external review under the Federal external review process. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

1. An Adverse Benefit Determination, if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
2. a Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

Preliminary review

Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.

Referral to Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice of final external review decision

The Plan's (or Contract Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Covered Person or Dependent on whose behalf such payment was made.

A Covered Person, Dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied. The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Covered Persons and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Covered Persons) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Covered Person(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

- In error.
- Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
- Pursuant to a misstatement made to obtain coverage under this Plan within 2 years after the date such coverage commences.
- With respect to an ineligible person.
- In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Third-Party Recovery, Subrogation and Reimbursement provisions; or
- Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision shall not be deemed to require the Plan to pay benefits under this Plan in any such instance. The deduction may be made against any claim for benefits under this Plan by a Covered Person or by any of his covered Dependents if such payment is made with respect to the Covered Person or any person covered or asserting coverage as a Dependent of the Covered Person. If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

1. **Accidental Injury –** An injury that results independently of an illness and all other causes and is the result of an externally violent force or accident.
2. **ADA –** The American Dental Association.
3. **Adverse Benefit Determination –** Any of the following:
   - A denial in benefits.
   - A reduction in benefits.
   - A recession of coverage.
   - A termination of benefits; or
   - A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
4. **Administrative Period (AP)** – The period of time between the IMP or SMP and the SP to determine which ongoing employees are eligible for coverage.
5. **Alternative Medicine** – Medical practices that are not considered a part of conventional medicine.
6. **AHA –** The American Hospital Association.
7. **Allowable Expenses –** The Usual and Customary charge for any Medically Necessary, Reasonable, and eligible items of expense, at least a portion of which is covered under a plan. When some other plan pays first in accordance with the Application to Benefit Determinations Section herein, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan (as defined herein)

provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

8. **AMA –** The American Medical Association.

9. **Ambulatory Surgical Center –** Any public or private establishment which:

   - complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located.
   - has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures.
   - provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and
   - does not provide services or other accommodations for patients to stay overnight.

10. **Approved Clinical Trial –** 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, 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).

    Effective January 1, 2014, 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.

11. **Assignment of Benefits –** An arrangement whereby the Covered Person, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less deductibles, co-payments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to a provider. If a provider accepts said arrangement, providers' rights to receive Plan benefits are equal to those of a Covered Person and are limited by the terms of this Plan Document. A provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" and deductibles, co-payments and the coinsurance percentage that is the responsibility of the Covered Person, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Covered Person as the sole beneficiary.

12. **Benefit Document –** A document that describes one (1) or more benefits of the Plan.

13. **Birthing Center –** A special room in a Hospital that exists to provide delivery and pre-natal and post- natal care with minimum medical intervention or a free-standing Outpatient facility which:

    - is in compliance with licensing and other legal requirements in the jurisdiction where it is located.
    - is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low risk patients.
    - has organized facilities for birth services on its premises.
    - provides birth services which are performed by or under the direction of a Physician specializing in obstetrics and gynecology.
    - has 24-hour-a-day registered nursing services.
    - maintains daily clinical records.

14. **Calendar Year –** The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

15. **Cardiac Rehabilitation –** A monitored exercise program directed at restoring both physiological and psychological well-being to individuals with heart disease.

16. **Child –** In addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, or any other Child for whom the Employee has obtained legal guardianship.

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

18. **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, provision or section may be amended from time to time.

19. **Claimant –** Any Covered Person on whose behalf a claim is submitted for benefits under the Plan.

20. **A Clean Claim** is one 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 defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. 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.

    Filing a Clean Claim. A provider submits a Clean Claim by providing the required data elements on the standard claim's forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan as well.

21. **Contract Administrator –** A company that performs all functions reasonably related to the administration of one or more benefits of the Plan (e.g., processing of claims for payment) in accordance with the terms and conditions of the Benefit Document and an administration agreement between the Contract Administrator and the Plan Sponsor.

    The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits under the Plan.

    See General Plan Information section

22. **Convalescent Hospital –** see "Skilled Nursing Facility"

23. **Covered Person –** A covered Employee, a covered Dependent, and a Qualified Beneficiary (COBRA). See **Eligibility and Effective Dates** and **COBRA Continuation Coverage** sections for further information.

    NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

24. **Covered Provider –** Any practitioner of the healing arts who:

    - is licensed and regulated by a state or federal agency and is acting within the scope of his or her license; or
    - in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association; and including, but not limited to a/an:
        - Acupuncturist (CA) or doctor of Chinese medicine
        - Audiologist
        - Certified or Registered Nurse Midwife
        - Certified Registered Nurse Anesthetist (CRNA)
        - Chiropractor (DC)
        - Dentist (DDS or DMD)
        - Hospitalist
        - Licensed Clinical Psychologist (PhD or EdD)
        - Licensed Clinical Social Worker (LCSW)
        - Licensed Practical Nurse (LPN)
        - Licensed Registered Dietician (RD)
        - Licensed Vocational Nurse (LVN)
        - Marriage Family and Child Counselor (MFCC)
        - Nurse Practitioner
        - Occupational Therapist (OTR)
        - Optometrist (OD)
        - Physical Therapist (PT or RPT)
        - Physician – see definition of "Physician"

- Podiatrist or Chiropodist (DPM, DSC or PodD)
- Psychiatrist (MD)
- Registered Dietitian (RD)
- Registered Nurse (RN)
- Respiratory Therapist
- Speech Pathologist
- Substance Use Disorder Counselor

A "Covered Provider" will also include the following when appropriately licensed and providing services which are covered by the Plan:

- facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, etc.
- licensed Outpatient mental health facilities.
- facilities for treatment of abuse of alcohol or drugs which are certified by the Bureau of Alcohol and Drug Abuse in the Rehabilitation Division of the Department of Human Resources of Nevada.
- Health care facilities which are licensed by the Health Division of the Department of Human Resources of Nevada, accredited by the Joint Commission of Accreditation of Hospitals and/or CIHQ and which provide programs for the treatment of alcoholism or drug abuse as part of their accredited activities.
- freestanding public health facilities.
- hemodialysis and Outpatient clinics under the direction of a Physician (MD);
- enuresis control centers.
- prosthetists and prosthetist-orthotists.
- portable X-ray companies.
- independent laboratories and lab technicians.
- diagnostic imaging facilities.
- blood banks.
- speech and hearing centers.
- ambulance companies.

NOTE: A Covered Provider does not include: (1) a Covered Person treating himself/herself or any relative or person who resides in the Covered Person's household – see "Relative or Resident Care" in the list of **General Exclusions**, or (2) any Physician, nurse or other provider who is an employee of a Hospital or other Covered Provider facility and who is paid by the facility for services.

25. **Day Care Center –** An Outpatient psychiatric facility which is part of or affiliated with a Hospital. It must be licensed according to state and local laws to provide Outpatient care and treatment of mental and nervous disorders or substance use disorders under the supervision of psychiatrists.
26. **Dependent –** see **Eligibility and Effective Dates** section
27. **Eligible Expense(s) –** Expense that is: (1) covered by a specific benefit provision of the Benefit Document and (2) incurred while the person is covered by the Plan.

28. **Emergency –** see "Medical Emergency"

29. **Employee –** An Employee is a person employed by the Employer as a common-law employee as determined solely by Employer's payroll records. "Employee" does not include a leased employee or any person who is not treated as an employee of the Employer for employment tax purposes, nor does it include any person who is a member of a collective bargaining unit for which benefits under this Plan have not been provided under the applicable collective bargaining agreement, regardless of how a court or government agency may otherwise rule or determine in the future (such court ruling or government agency determination shall not have retroactive effect).

30. **Employer(s) –** The Employer or Employers participating in the Plan as stated in the **General Plan Information** section.

31. **Essential Health Benefits –** Under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic Disease management; and pediatric services, including oral and vision care.

32. **Experimental and/or Investigational (Experimental) –** Services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long- term outcomes from those services or treatments, and that are not the subject of, or in some manner 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 which:

    - Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
    - Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

    A Drug, device, or medical treatment or procedure is Experimental:

    - If the Drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the Drug or device is furnished.
    - If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
        - maximum tolerated dose.
        - toxicity.
        - safety.
        - efficacy; and
        - efficacy as compared with the standard means of treatment or Diagnosis; or

      If reliable evidence shows that the consensus among experts regarding the Drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:

        - maximum tolerated dose.
        - toxicity.
        - safety.

- efficacy; and
- efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean:

- only published reports and articles in the authoritative medical and scientific literature.
- the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same Drug, device, or medical treatment or procedure; or
- the written informed consent used by the treating facility or by another facility studying substantially the same Drug, device, or medical treatment or procedure.

Notwithstanding the above, a prescription Drug for a treatment that has been approved by the FDA but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription Drug provided that the Drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed according to the Plan Off-Label Use Policy.

33. **Fiduciary –** A Fiduciary of the Plan is any entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.
34. **Final Internal Adverse Benefit Determination –** An Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.
35. **FMLA –** The Family and Medical Leave Act of 1993, as amended.
36. **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.
37. **HIPAA –** The Health Insurance Portability and Accountability Act of 1996, as amended.
38. **Home Health Care Agency –** An agency or organization which:
    - is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services.
    - has policies established by a professional group associated with the agency or organization which includes at least one registered nurse (RN) to govern the services provided.
    - provides for full-time supervision of its services by a Physician or by a registered nurse.
    - maintains a complete medical record on each patient.
    - has a full-time administrator.

    In rural areas where there are no agencies which meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.
39. **Hospice** or **Hospice Agency –** An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one registered nurse and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

40. **Hospital –** A lawfully operated institution engaged primarily in providing care and treatment for sick or injured persons by or under the supervision of a Physician, with 24-hour nursing service by a registered nurse (RN). In addition, it must have organized facilities for diagnosis and major Surgery.

    A “Hospital” will also include:

    - a licensed facility for the care and treatment of mental illness, alcoholism or drug addiction, even if it does not have surgical facilities, as long as it otherwise qualifies as a Hospital.
    - any facility for treatment of abuse of alcohol or drugs which is certified by the Bureau of Alcohol and Drug Abuse in the Rehabilitation Division of the Department of Human Resources of Nevada.
    - any health care facility which is licensed by the Health Division of the Department of Human Resources of Nevada, accredited by the Joint Commission of Accreditation of Hospitals and provides a program for the treatment of alcoholism or drug abuse as part of its accredited activities.

    NOTE: A “Hospital” does not include a rest home, nursing home, convalescent home, old age home, rehabilitative facility, or Skilled Nursing Facility.

41. A Covered Expense is **Incurred** on the date the service is rendered, or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

42. **Initial Measurement Period (IMP)** – Period of time, to be determined solely at the discretion of CTHS, between three and twelve months from employee date of hire to measure completed hours of service for newly hired variable hour and seasonal employees. This period is used to determine whether an employee completed an average of thirty hours of service per week.

43. **Inpatient –** A person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) which is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises.

44. **Intensive Care Unit** (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit – A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, which provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand- by basis and which is separated from the rest of the Hospital's facilities.

45. **Lifetime –** All periods an individual is covered under the Plan, including any prior statements of the Plan. It does not mean a Covered Person's entire lifetime.

46. **Maximum Amount and/or Maximum Allowable Charge –** The benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) may be the lesser of:

    - the Usual and Customary amount.
    - the allowable charge specified under the terms of the Plan.
    - the Reasonable charge specified under the terms of the Plan.
    - the negotiated rate established in a contractual arrangement with a Provider; or
    - the actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

47. **Medical Emergency –** A situation which arises suddenly, and which either poses a serious threat or causes serious impairment of bodily functions, and which requires immediate medical attention or hospitalization. This includes conditions arising as the result of accidental bodily injury and any of the following conditions or symptoms: acute severe abdominal pains, poisoning, vomiting, acute chest pains (angina, suspected heart attack, coronary, pneumothorax), shortness of breath, asthma, allergic reaction to drugs, angioneurotic edema, convulsions, coma, syncope, fainting, shock, hemorrhage, acute urinary retention, epistaxis (severe nose bleed), or high fever of at least 104 degrees.

    Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

48. **Medically Necessary –** health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an Illness or Injury or its symptoms in a manner that is:

    - in accordance with generally accepted standards of medical practice in the United States.
    - clinically appropriate in terms of type, frequency, extent, site, and duration.
    - not primarily for the convenience of the patient, Physician, or other health care provider.
    - covered under the Plan; and
    - not more costly than an alternative drug, service(s), or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Illness, Injury, disease, or symptoms.

    When a medical question-of-fact exists, Medical Necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harm to the individual, and that is known to be effective. For Health Interventions not yet in widespread use, the effectiveness shall be based on Scientific Evidence. For established Health Interventions, the effectiveness shall be based on first Scientific Evidence; then professional standards; and then expert opinion.

    A HEALTH INTERVENTION MAY BE MEDICALLY INDICATED YET NOT BE A COVERED SERVICE UNDER THE PLAN OR OTHERWISE MEET THIS DEFINITION OF MEDICAL NECESSITY.

49. **Medical Record Review –** The process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the **Maximum Allowable Charge** according to the Medical Record Review and audit results.

50. **Medicare –** Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A, B & D and Title XVIII of the Social Security Act, and as amended from time to time.

51. **Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA –** In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

- The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

- The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

52. **Mental or Nervous Disorder –** Any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous 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 or other relevant State guideline or applicable sources.

53. **Ongoing Employee** – An individual employed for at least one complete SMP.

54. **Outpatient –** Services rendered on other than an Inpatient basis at a Hospital or at a covered non- Hospital facility.

55. **Partial Hospitalization –** A planned partial confinement treatment program of psychiatric services for the treatment of mental health conditions which is given in a Hospital or in a treatment facility on less than a full-time Inpatient basis and which meets the following requirements:

    - it involves a generally accepted form of evaluation and treatment of a condition diagnosed as a mental illness which does not require full-time confinement in a Hospital or treatment facility.

    - it is supervised by a psychiatric Physician who both reviews the program and evaluates its effectiveness at least once a week.

    - for partial day care, the facility's treatment program must be available for at least six (6) hours during the day and at least five (5) days a week.

    - for night care, the facility's treatment program must be available for at least eight (8) hours a night and at least five (5) nights a week.

56. **Participating Employer –** An Employer who is participating in the coverages of the Plan. See **General Plan Information** section for the identity of the Participating Employer(s)

57. **Physician –** A Doctor of Medicine (MD), or Doctor of Osteopathy (DO), who is licensed to practice medicine or osteopathy where the care is provided and who acts within the scope of his or her license.

    A Physician will also include a Christian Science practitioner accredited by the Mother Church – The First Church of Christ, Scientist, in Boston, Massachusetts. See NOTE.

    NOTE: The term "Physician" will not include the Covered Person himself/herself, relatives (see **General Exclusions**) or interns, residents, fellows or others enrolled in a graduate medical education program.

58. **Plan –** The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the **General Plan Information** section.

59. **Plan Administrator** – The entity with the authority to interpret the Plan and make determinations regarding coverage, eligibility, and benefits. See **General Plan Information** section for further information."

60. **Plan Document –** A formal written document that describes the Plan and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments.

61. **Plan Sponsor –** The entity sponsoring this Plan and with the authority to modify or amend the Plan. See **General Plan Information** section for further information.

62. **Practitioner –** See "Covered Provider"

63. **Pregnancy –** Pre-natal and post-natal care during pregnancy, childbirth, miscarriage or complications arising therefrom. See "Pregnancy" in the list of **Eligible Medical Expenses** for further information.

64. **Preventative Care** – This Plan intends to comply with the Patient Protection and Affordable Care Act's (PPACA) requirement to offer in-Network coverage for certain preventive services without cost sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

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

    Copies of the recommendations and guidelines may be found here: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendationsor at www.healthcare.gov/prevention.

65. **Prior to Effective Date or After Termination Date –** Dates occurring before a Covered Person gains eligibility from the Plan, or dates occurring after a Covered Person loses eligibility from the Plan, as applicable.

66. **Reasonable and/or Reasonableness –** In the Plan 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 Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

    This determination will consider, but will not be limited to, 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. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. 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 but not limited to CMS guidelines.

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

67. **Rehabilitation Therapy –** Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery and that is performed by a licensed therapist acting within the scope of his or her license.

    Active rehabilitation refers to therapy in which a patient, who has the ability to learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

    Maintenance rehabilitation refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonable be prescribed to maintain, support, and/or preserve the patient's functional level. Maintenance rehabilitation is not covered.

    Passive rehabilitation refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive rehabilitation may be covered by the Plan, but only during a course of hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an Outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation.

    Continued hospitalization for the sole purpose of providing passive rehabilitation is not considered to be Medically Necessary.

68. **Semi-Private Room Charge –** The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or 90% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

69. **Sickness –** Sickness will mean bodily illness or disease (other than mental health conditions), congenital abnormalities, birth defects and premature birth. Also, a condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

70. **Skilled Nursing Facility –** An institution which:

    - is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations.
    - is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day for convalescing persons.
    - is under the full-time supervision of a Physician or a registered nurse.
    - admits patients only upon the recommendation of a Physician, maintains complete medical records, and has available at all times the services of a Physician.
    - has established methods and procedures for the dispensing and administering of drugs.
    - has an effective utilization review plan.
    - is approved and licensed by Medicare.
    - has a written transfer agreement in effect with one or more Hospitals; and
    - is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

71. **Stability Period (SP)** – A period of time, to be determined solely at the discretion of CTHS, of at least six consecutive calendar months that is no shorter in duration than the IMP or SMP and begins after the IMP or SMP and any applicable Administrative Period for an Employee determined to be a full- time Employee during the SMP.

72. **Standard Measurement Period (SMP)** – Period of time, to be determined solely at the discretion of CTHS, between three and twelve months from the Employee's date of hire to measure completed hours of service for ongoing variable hour and seasonal Employees. This period is used to determine whether an Employee completed an average of thirty hours of service per week.

73. **Substance Use Disorder –** Any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic 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 follows:

    - 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 (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
        - Recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by substance use).
        - Craving or a strong desire or urge to use a substance; or
        - Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

74. **Surgery –** Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one (1) surgical procedure is performed through the same incision or operative field or at the same operative session, the Contract Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered included as a single procedure for the purpose of determining Plan benefits.

    Allowances for multiple surgeries through the same incision or operational field:

    - the primary procedure is allowed at 100% of Usual and Customary and Reasonable.
    - the secondary and additional procedures are allowed at 50% of Usual Customary and Reasonable, per procedure.

    Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

    - The first site primary procedure is allowed at 100% of Usual and Customary and Reasonable.
    - The first site secondary and additional procedures are allowed at 50% of Usual and Customary and Reasonable, per procedure.
    - The second site primary procedure is allowed at 100% of Usual and Customary and Reasonable; and
    - The second site secondary and additional procedures are allowed at 50% of Usual and Customary and Reasonable, per procedure.

75. **Urgent Care Facility –** A facility which is engaged primarily in providing minor emergency and episodic medical care and which has:

    - A board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times.
    - X-ray and laboratory equipment and a life support system.

    An Urgent Care Facility may include a clinic located at, operated in conjunction with, or which is part of a regular Hospital.

76. **Usual and Customary (U&C) –** With regard to charges made by any PPO and Non-PPO provider, the Usual and Customary will be:

    - PPO or Participating Provider – Usual and Customary for a PPO provider will be the contracted rate set forth in the agreement between the Preferred Provider Network or the Plan.
    - Non-PPO Provider – Usual and Customary for a Non-PPO provider will be the fee that is allowed for a PPO provider for the same or similar service. The amount in excess of the allowable will be the patient's responsibility.

    When determining whether an expense is Usual and Customary, the Plan Administrator will take into consideration the fee(s) which the provider most frequently charges the majority of patients for the service or supply and the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply. The terms "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 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 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 Covered Person by a provider or services or supplies, such as a physician, therapist, nurse, hospital or pharmacist. The Plan Administrator 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 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 services and supplies and devices.

    The Claims Administrator has the discretionary authority to determine the Usual and Customary Charge based upon standards set forth by the Plan Administrator.

GENERAL PLAN INFORMATION

Name of Plan	**Carson Tahoe Health System** **Group Health Plan**
Plan Sponsor	**Carson Tahoe Health System** 1600 Medical Parkway Carson City, NV 89703 775-445-8000
Plan Administrator	**Carson Tahoe Health System** 1600 Medical Parkway Carson City, NV 89703 775-445-8000
Participating Employer(s)	**Carson Tahoe Health System**
Plan Year	**January 1 through December 31**
Plan Number	**505**
Plan Status	**Non-Grandfathered**
Name Fiduciary	**Carson Tahoe Health System** 1600 Medical Parkway Carson City, NV 89703
Agent for Service of Legal Process	**Carson Tahoe Health System** 1600 Medical Parkway Carson City, NV 89703 Service of process may also be made upon the Plan Administrator
Type of Plan	**This is an employee welfare benefit plan providing group benefits**
Plan Benefits Described Herein	**Self-funded Medical, Dental and Prescription Benefits**
Type of Administration	**Contract Administration – see "Administrative Provisions" for additional information**
Privacy Officer	**775-445-8010**
Contract Administrator	**Hometown Health Plan** 10315 Professional Circle Reno, NV 89521 775-982-5885

FUNDING – SOURCES AND USES

Employee & Employer Obligations

The benefits provided under this Plan are self-funded. Consequently, Plan benefits are paid in part by Employee contributions and, to the extent necessary, in part by Plan Sponsor contributions from its general assets. The Plan Administrator shall, from time to time, evaluate and determine the amount to be contributed, if any, by each Employee or Plan participant.

COBRA premiums are fully the Employee's or Qualified Beneficiary's responsibility and are generally 102% of the full cost of coverage for active (Non-COBRA) enrollees, except in special circumstances where a greater cost is allowed by law. See the **COBRA Continuation Coverage** section for more information.

The Employer provides eligible Employees the opportunity to pay for certain benefit programs on a pre-tax basis through a cafeteria plan. Provided the Employee makes a proper election under the cafeteria plan, the Employee's share of any applicable premium cost(s) will be deducted on a regular, pre-tax basis from his wages or salary. Cafeteria plan rules can affect when and under what circumstances Employees can change their pre-tax deduction elections. Refer to the cafeteria plan open enrollment rules for more information. In other instances, the Employee or Plan participant will be responsible for remitting payment for premium contributions to the Employer in a timely manner, as prescribed by the Employer.

Plan Funded Benefits

Employee contributions will be applied toward providing the benefits under the Plan. In addition, the Plan Sponsor will make contributions toward the payment of benefits under the Plan from its general assets.

Taxes

Any premium or other taxes which may be imposed by any state or other taxing authority, and which are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

NOTE: To provide benefits, purchase insurance protection, pay administrative expenses and any necessary taxes, the contributions which are paid by Employees will be used first, and any remaining Plan obligations will be paid by Employer contributions out of its general assets. Should total Plan liabilities in a Plan Year be less than total Employee contributions, any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at the Plan Sponsor's discretion, may be used in any other manner which is consistent with ERISA guidelines.

ADMINISTRATIVE PROVISIONS

Administration (type of)

Certain benefits of the Plan are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

Alternative Care

In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any Provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to administer the Plan thereafter in strict accordance with the provisions of the Benefit Document.

Amendment or Termination of the Plan

Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

- determine eligibility for benefits or to construe the terms of the Plan in its sole discretion.
- alter or postpone the method of payment of any benefit.
- amend any provision of these administrative provisions.
- make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the Internal Revenue Code or ERISA; and
- terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis (to the extent permitted by law), provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he/she has become entitled under the Plan.

NOTE: Any modification, amendment or termination action will be done in writing. Employees will be provided with notice of the change within the time allowed by federal law.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), any amendment limiting benefits under a Plan shall be universally applicable to all individuals in the same eligible class, shall be based on bona fide employment classifications consistent with the Employer's usual business practices, and shall not be directed at individual participants or beneficiaries based on any health factor of such individual(s). However, a Plan amendment applicable to all individuals in one or more groups of similarly situated individuals and made effective no earlier than the first day of the first Plan Year after the amendment is adopted is not considered to be directed at individual participants and beneficiaries.

Anticipation, Alienation, Sale or Transfer

Except for valid assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to so anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities,

engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error

Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Creditable Coverage Certificates

Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a “certificate of creditable coverage” or “certificate of group health plan coverage,” from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits under the Plan), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

Discrepancies

In the event that there may be a discrepancy between the booklet(s) provided to Employees, the SPD, and the Benefit Document, the Benefit Document will prevail.

Facility of Payment

Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he/she can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciary Responsibility, Authority and Discretion

Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and

entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number

Except when otherwise indicated by the context, any masculine terminology in this SPD will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

Illegality of Particular Provision

The illegality of any particular provision of the Benefit Document or SPD will not affect the other provisions, but the Benefit Document and SPD will be construed in all respects as if such invalid provision were omitted.

Indemnification

To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions

No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Benefit Document and Plan Document.

No legal action must be brought (i.e., the lawsuit must be filed with the applicable court) within three years from the time written proof of loss is required to be given. No legal action can be brought until the Plan’s mandatory claim appeal(s) are exhausted. If a Covered Person fails to exhaust the Plan’s mandatory claim appeal(s), the Covered Person is prohibited from bringing legal action regarding such claim and waives all legal rights associated with such claim, and the Contract Administrator’s decision shall be final and binding. See the **Claims Procedures** section for more information.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Loss of Benefits

To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

- an Employee's cessation of active service for the Employer.
- a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner (including any applicable grace periods).
- a Dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces).
- A Plan participant is injured and expenses for treatment may be paid by or recovered from a third party.
- a claim for benefits is not filed within the time limits of the Plan.

Material Modification

In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

"Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage. Such reductions are outlined by the Department of Labor in Section 2520.104b-3(d)(3) of the regulations.

Misstatement / Misrepresentation

If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his/her eligibility, benefits or both, will be adjusted to reflect his/her true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Misuse of Identification Card

If an Employee or covered Dependent knowingly permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his/her (and his/her family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Non-Discrimination Due to Health Status

An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition
- (whether physical or mental and including conditions arising out of acts of domestic violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability
- disability
- genetic information

Not a Contract

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

Physical Examination

The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Privacy Rules & Security Standards & Intent to Comply

To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the “Privacy Rules”) of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with HIPAA Security Rule with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against Employees who file complaints with regard to their privacy, and Employees will not be required to give up their privacy rights in order to enroll or have benefits under the Plan.

Purpose of the Plan

The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

Reimbursements

Plan's Right to Reimburse Another Party – Whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Clerical Error – When, as a result of clerical error, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claim's payable to the Employee or any of his/her Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability – The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claim's payable to the Employee or any of his/her Dependents.

Rights Against the Plan Sponsor or Employer

Except as required by law, neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Titles or Headings

Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

Termination for Fraud

A Covered Person's Plan coverage or eligibility for coverage under the Plan may be terminated if:

- The individual submits any claim that contains false or fraudulent elements under state or federal law.
- A civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law.
- An individual has submitted a claim which, in good faith judgment and investigation, he/she knew or should have known, contained false or fraudulent elements under state or federal law.

Termination for fraud will be made in writing and with 31-day notice to all affected individuals.

Type of Plan

This Plan is a group health plan which is governed by the Employee Retirement Income Security Act (ERISA) and subject to the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). The Employer-funded ("self-funded") benefits of the Plan are not guaranteed under a contract or policy of insurance.

Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, which is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law, but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

If a retired Employee is covered under the Plan and one of his/her covered Dependents experiences a Qualifying Event resulting in a loss of coverage under the Plan (e.g., divorce, loss of Dependent child eligibility, etc.), such Dependent may be eligible for COBRA Continuation Coverage. Also, certain other COBRA rights apply to such covered retirees and their covered Dependents with regard to an Employer's bankruptcy. Anywhere "retirees" are referenced herein, it means only those retired Employees who are covered under the Plan.

Definitions – When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary – An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer coverage constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event – Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

- voluntary or involuntary termination of the Employee's employment, provided termination is due to any reason other than Employee’s gross misconduct as determined by Employer in accordance with applicable law.
- reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not the Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave.
- for an Employee's covered spouse or child, the Employee’s entitlement to Medicare (under Part A, Part B, or both). For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is in effect.
- for an Employee's covered spouse or child, the divorce or legal separation of the Employee and spouse.
- for an Employee's covered spouse or child, the death of the covered Employee.

- for an Employee's covered child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit);
- for covered retirees and their covered Dependent spouses and children, loss of Plan coverage due to the Employer's filing of a bankruptcy proceeding under Title 11 of the U.S. Bankruptcy Code. In order for a Qualifying Event to occur, the Employee must have retired on or before the date of substantial elimination of the Plan's benefits and must be covered under the Plan on the day before the bankruptcy proceedings begin. "Substantial elimination" of the Plan's benefits must occur within 12 months before or after the bankruptcy proceedings begin.

Non-COBRA Beneficiary – An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notification Responsibilities – If the Employer is the Contract Administrator and if the Qualifying Event is the covered Employee's termination/reduction in hours, death, or Medicare entitlement, then the Contract Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Contract Administrator, then the Employer's notification of these Qualified Events to the Contract Administrator must occur within 30 days of the Qualifying Event and the Contract Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay the required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Contract Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to elect COBRA continuation coverage.

A covered Employee or covered Dependent is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse. A covered Employee or covered Dependent may also be responsible for other notifications. See the **COBRA Notification Procedures** Section as included in this SPD (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Contract Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

Election and Election Period – COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose to elect COBRA continuation coverage, even if other Qualified Beneficiaries have declined. A parent or legal guardian may elect or decline COBRA continuation coverage for minor Dependent children.

An election of an incapacitated Qualified Beneficiary can be made by the legal representative of the Qualified Beneficiary, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Contract Administrator.

Open enrollment rights that allow Non-COBRA Beneficiaries to choose among any available coverage options under the Plan are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the “Effect of the Trade Act” provision for information regarding a second 60-day election period allowance.

Effective Date of Coverage – COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits – COBRA continuation coverage will be equivalent to coverage provided to similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated Non-COBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage – The cost of COBRA continuation coverage will not exceed 102% of the Plan’s full cost of coverage during the same period for similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. The “full cost” includes any part of the cost that is paid by the Employer for Non-COBRA Beneficiaries. Qualified Beneficiaries can be charged up to 150% of the full cost during the 11-month disability extension period.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Contract Administrator permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Contract Administrator.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium payment invoices or notices.

The cost of COBRA continuation coverage can only increase if:

- The cost previously charged was less than the maximum permitted by law.
- The increase is due to a rate increase at Plan renewal.
- the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law that is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or
- The Qualified Beneficiary changes his coverage option(s) that results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment deficiency will be considered an "insignificant shortfall" if it is not greater than $50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of an applicable period of coverage (e.g., a month), the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage (e.g., the beginning of the month for which the premium was due).

NOTE: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically indigent or due to a certain disability. The Employer’s personnel offices should be contacted for additional information.

See the “Effect of the Trade Act” provision for additional cost of coverage information.

Maximum Coverage Periods – The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

- if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months.
- if the Qualifying Event occurs to a covered Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare.
- in the case of a bankruptcy Qualifying Event with regard to a covered retiree, the maximum coverage period is to the date of the retired Employee's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse or Dependent child of the retired Employee ends on the earlier of: (1) 36 months after the death of the retired Employee, or (2) the date of the Qualified Beneficiary's death.
- for any other Qualifying Event, the maximum coverage period for Qualified Beneficiaries ends 36 months after the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that is the death of a covered Employee, the divorce or legal separation of the covered Employee and his/her spouse, a covered Employee’s becoming entitled to Medicare, or a loss of Dependent child status under the Plan, the original period will be expanded to 36 months, but only for Qualified Beneficiaries who were not the covered Employee. In no circumstance can the COBRA continuation coverage period be more than

36 months after the date of the first Qualifying Event, except in the case of bankruptcy Qualifying Event with regard to a covered retiree.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) – USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension – An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Contract Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Contract Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by the Social Security Administration to be no longer disabled.

If a Qualified Beneficiary who is eligible for the 11-month disability extension also has family members who are Qualified Beneficiaries entitled to COBRA continuation coverage, those family members are also entitled to the 11-month disability extension period.

Termination of Continuation Coverage – Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

- the last day of the applicable maximum coverage period – see "Maximum Coverage Periods" above.
- the date on which the Employer ceases to provide any group health plan to any Employee.
- The date, after the date of the COBRA election, the Qualified Beneficiary first becomes covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition that would reduce or exclude benefits for such conditions for the Qualified Beneficiary.
- the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect.

In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

- 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier: or
- the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.
- the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly situated Non-COBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during a Covered Employee's COBRA continuation coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

Effect of the Trade Act – In response to Public Law 107-210, referred to as the Trade Act of 2002 ("TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, and the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals – The Contract Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Contract Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement, federal income tax filings, etc. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension Of Cobra Election Period

Definitions:

- Non-electing TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.
- TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.
- TAA-Related Election Period – With respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA- Eligible Individual.
- TAA-Related Loss of Coverage – Means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Non-electing TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than six (6) months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period and shall not include any period prior to the such individual's TAA-Related Election Period.

HIPAA Creditable Coverage Credit

With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a Non-electing TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage.

Applicable Cost Of Coverage Payments

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed to the Plan by such individual is determined to be significantly less than the required applicable cost of coverage,

as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise, the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

COBRA NOTIFICATION PROCEDURES

NOTICE RESPONSIBILITIES

It is a Covered Person's responsibility to provide the following notices relating to COBRA continuation coverage:

- **Notice of Divorce or Separation –** Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a Covered Person from his or her spouse.
- **Notice of Child's Loss of Dependent Status –** Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (e.g., a Dependent child reaching the maximum age limit).
- **Notice of a Second Qualifying Event –** Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA coverage with a maximum duration of 18 (or 29) months.
- **Notice Regarding Disability –** Notice that: (a) a Qualified Beneficiary entitled to receive COBRA continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration (SSA) to be disabled as of the date of the Qualifying Event or at any time during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the SSA to no longer be disabled.
- **Notice Regarding Address Changes –** It is important that the Contract Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

NOTIFICATION PROCEDURES

Notification must be made in accordance with the following procedures. Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the notice. Notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form or Means of Notification – Notification of the Qualifying Event must be provided to the CTHS Human Resources office. You may contact the Human Resources office to fill out an enrollment form stating the qualifying event.

Content – Notification must include any official documentation showing evidence that a Qualifying Event has occurred, such as a copy of a divorce decree, a child's birth certificate, a copy of the Social Security Administration's disability determination, etc.

Delivery of Notification – Notification must be received by the CTHS Human Resources office.

Time Requirements for Notification – Should a Qualifying Event or other event occur (as described in **NOTICE RESPONSIBILITIES** above), the Employee, other Qualified Beneficiary, or a representative acting on behalf of any such person) must provide notice to the designated recipient within a certain time frame.

In the case of a divorce, legal separation or a child losing dependent status, notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date Plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide notice through the SPD or the Contract Administrator's General COBRA Notice. If notice is not received within the 60-day period, COBRA continuation coverage will not be available for election, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see "Effect of the Trade Act" in the **COBRA Continuation Coverage** section of this SPD.

If a Qualified Beneficiary is determined to be disabled under the Social Security Act, notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying Event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the Qualified Beneficiary is advised of the notice obligation through the SPD or the Contract Administrator's General COBRA Notice. Notice must be provided within the 18- month COBRA coverage period. Any such Qualified Beneficiary must also provide notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

The Plan will not reject an incomplete notice as long as the notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

HIPAA PRIVACY

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of PHI of Covered Persons. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

- the Plan's disclosures and uses of PHI.
- the Covered Person's privacy rights with respect to his/her PHI.
- the Plan's duties with respect to PHI.
- the Covered Person's right to file a complaint with the Plan and with the Secretary of the United States Department of Health and Human Services (HHS); and
- the person or office to contact for further information about the Plan's privacy practices.

Within this section, capitalized terms may be used but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this section. In the event of any discrepancy between this section and applicable law, applicable law will prevail, and the Plan will abide by and adhere to applicable law.

How Health Information May be Used and Disclosed

In general, the Privacy Rule permits the Plan to use and disclose the minimum necessary amount of an individual's PHI, without obtaining authorization, only if the use or disclosure is:

- to carry out Payment of benefits.
- for Health Care Operations.
- for Treatment purposes; or
- if the use or disclosure falls within one of the limited circumstances described in the Privacy Rule (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

The Plan may disclose PHI to the Plan Sponsor in order to permit the Plan Sponsor to carry out Plan administration activities. In order that the Plan Sponsor may receive and use PHI for Plan administration purposes, the Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Rule);
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
- establish safeguards for the PHI, including security systems for data processing and storage.
- maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
- receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
- not use or disclose genetic information for underwriting purposes.
- not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Rule.
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
- make available PHI in accordance with Section 164.524 of the Privacy Rule (45 CFR 164.524);
- make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Rule (45 CFR 164.526).
- make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Rule (45 CFR 164.528);
- make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of HHS, or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Rule (45 CFR 164.500 et seq.);
- train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections.
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Rule (45 CFR 164.504(f)(2)(iii)), is established as follows:

  the following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

  > Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non- compliance occurs. The Plan Administrator will promptly report such violation or non- compliance to the Plan and will cooperate with the Plan to correct violation or non- compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the Plan for purposes of Plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the Plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Rule (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Contract Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered

Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information; and

Other Covered Entities: The Plan may disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

A public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect.

Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration (FDA) or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities.

Locate and notify persons of recalls of products they may be using; and

A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law.

The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Covered Person's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Covered Person that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (any such disclosures will be made only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives, although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Covered Person's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Covered Person of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;

Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Covered Person's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Plan Sponsor's or Plan's premises.

Decedents: The Plan may disclose PHI to family members or others involved in a decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years.

Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and

Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Covered Person; and

Disclosures to the Secretary of HHS: The Plan is required to disclose the Covered Person's PHI to the Secretary of HHS when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed From Covered Persons Before Disclosing PHI

- Most uses and disclosures of psychotherapy notes.
- Uses and disclosures for marketing.
- Sale of PHI; and
- Other uses and disclosures not described herein or provided for under applicable law can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

Covered Person's Rights

The Covered Person has the following rights regarding PHI about him/her:

Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for Treatment, Payment, or Health Care Operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

Right to Receive Confidential Communication: The Covered Person has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and should indicate how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.

Right to Receive Notice of Privacy Practices: The Covered Person is entitled to receive a paper copy of the Plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for Treatment, Payment, Health Care Operations, and certain other purposes provided by applicable law. The Covered Person is entitled to such an accounting for the 6 years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and (e) certain other information. If the Covered Person wishes to make a request for an accounting, please contact the Privacy Compliance Coordinator.

Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he/she may be charged a reasonable fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.

Amendment: The Covered Person has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. The Covered Person should submit the request to the Privacy Compliance Coordinator. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and

Fundraising contacts: The Covered Person has the right to opt out of fundraising contacts.

Notification Requirements in the Event of a Breach of Unsecured ePHI

HIPAA contains breach notification rules that require HIPAA covered entities (such as the Plan) and their business associates to provide notification following a breach of unsecured protected health information (PHI). The rules are contained at 45 CFR §§ 164.400-414. The required breach notifications are triggered upon the discovery of a Breach (as defined under HIPAA) of unsecured PHI. A Breach is discovered as of the first day the Breach is known or reasonably should have been known.

When a Breach of unsecured PHI is discovered, the Plan will:

Notify the Covered Person whose PHI has been, or is reasonably believed to have been, accessed, acquired, used, or disclosed as a result of the Breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the Breach. Breach notification must be provided to these individuals by:

Written notice by first-class mail to the Covered Person (or next of kin) at last known address or, if agreed to by the Covered Person, e-mail.

If the Plan has insufficient or out-of-date contact information for the Covered Person, the Covered Person must be notified by a "substitute form".

If an urgent notice is required, the Plan may contact the Covered Person by telephone.

The Breach notification will have the following content:

Brief description of what happened, including date of the Breach and the date discovered.

Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);

Steps the Covered Person should take to protect himself from potential harm.

What the Plan is doing to investigate the Breach, mitigate losses and protect against further Breaches; and

Contact information for the Plan.

Notify the media if the Breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the Breach was discovered.

Notify the Secretary of HHS contemporaneously with the notice to the affected individuals and in the manner specified by HHS if the Breach involves 500 or more individuals. If the Breach involves less than 500 individuals, an internal log or other documentation of such Breaches must be maintained by the Plan and annually submitted to HHS within 60 days after the end of each Calendar Year; and

When a Business Associate, which provides services for or on behalf of the Plan and comes in contact with PHI in connection with those services, discovers a Breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a Breach so that the affected Covered Persons may be properly notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, Breached, as well as any additional available information required to be provided by the Plan in its notification to affected individuals.

Questions or Complaints

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services

Contact Information

Compliance/Legal Department
Carson Tahoe Health System
1600 Medical Parkway Carson City, NV 89703
Phone: 775-445-8776 or 775-445-8782
Fax: 775-445-8794

HIPAA SECURITY

HIPAA STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule establishes standards for maintaining the integrity, confidentiality and availability of protected health information that a "covered entity" creates, receives, maintains, or transmits electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Rule regulations (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.

- **Security Incidents,** as defined within Section 164.304 of the Security Rule regulations (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Obligations

The Security Rule requires that the Plan maintain appropriate and reasonable administrative, technical, and physical safeguards for protecting ePHI. Specifically, the Plan is required to:

- Ensure the confidentiality, integrity, and availability of all ePHI that the Plan creates, receives, maintains, or transmits.

- Identify and protect against reasonably anticipated threats to the security or integrity of the ePHI.

- Protect against reasonably anticipated, impermissible uses or disclosures of ePHI; and

- Ensure compliance by any person performing services for or on behalf of the Plan.

The Plan's duties and responsibilities with respect to maintaining appropriate and reasonable safeguards include (but are not limited to):

- Performing risk analysis to determine and evaluate which security measures are appropriate and reasonable for the Plan to adopt and maintain, including evaluating the likelihood and impact of potential risks to ePHI.

- Implement security measures that reduce risks and vulnerability to ePHI.

- Designate a security official who is responsible for developing and implementing its security policies and procedures.

- Perform periodic assessments of how well its security policies and procedures meet the requirements of the Security Rule.

- Implement policies and procedures to specify proper use or access to electronic media where ePHI may be accessed.

- Implement technical policies and procedures that allow only authorized personnel to access ePHI.

- Implement security measures that guard against unauthorized access to ePHI that is being transmitted over an electronic network; and

- Implementing policies and procedures to ensure that ePHI is not improperly altered or destroyed.

Questions or Complaints

If the Covered Person wants more information about the Plan's security practices with respect to ePHI, please contact the Plan using the following information.

Compliance/Legal Department
Carson Tahoe Health System
1600 Medical Parkway Carson City, NV 89703
Phone: 775-445-8776 or 775-445-8782
Fax: 775-445-8794

Any terms not otherwise defined in this section shall have the meanings set forth in HIPAA and its implementing regulations.

STATEMENT OF RIGHTS

As a participant in this Plan, an individual is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- examine, without charge, at the Contract Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
- obtain, upon written request to the Contract Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Contract Administrator is required by law to furnish each participant with a copy of this summary annual report.
- continue health care coverage for himself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The Employee or his Dependents may have to pay for such coverage. See the **COBRA Continuation Coverage** section for additional details about these rights.
- An individual should be provided a certificate of creditable coverage, free of charge, from his group health plan or health insurance issuer when he loses coverage under a plan, when he becomes entitled to elect COBRA continuation coverage, when his COBRA continuation coverage ceases, if he requests it before losing coverage or if he requests it up to 24 months after losing coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan (the Fiduciaries). Fiduciaries have a duty to operate the Plan prudently and in the interest of Plan participants and beneficiaries. No one, including the Employer, may fire a Plan participant or discriminate against him to prevent him from obtaining a welfare benefit or exercising rights under ERISA.

If an individual's claim for a welfare benefit is denied or ignored in whole or in part, he must receive a written explanation of the reason for the denial. He has the right to obtain copies of documents relating to the decision without charge and to have the Plan review and reconsider his claim, all within certain time schedules.

Under ERISA, there are steps he can take to enforce the above rights. For instance, if he requests a copy of plan documents or the latest annual report from the Plan and does not receive them within 30 days, he may file suit in a Federal court. In such a case, the court may require the Contract Administrator to provide the materials and pay him up to $110 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Contract Administrator. If he has a claim for benefits which is denied or ignored, in whole or in part, he may file suit in a state or Federal court but not before he exhausts the Plan's mandatory appeals process, where applicable (see the **Claims Procedures** section). In addition, if he disagrees with the Plan Sponsor's decision or lack thereof concerning the qualified status of a medical child support order (QMCSO), he may file suit in Federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if he is discriminated against for asserting his rights, he may seek assistance from the U.S. Department of Labor, or he may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If he is successful, the court may order the person he has sued to pay these costs and fees. If he loses, the court may order him to pay these costs and fees, for example, if it finds his claim is frivolous.

If an Employee or Plan participant has any questions about the Plan, he should contact the Contract Administrator. If he has any questions about this statement or about his rights under ERISA, he should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in his telephone directory; or

- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

An Employee or Plan participant may also obtain certain publications about his rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Carson Tahoe Health System. (the "Company" or the "Plan Sponsor") as of January 1, 2026, restates the Carson Tahoe Health System Group Health Benefit Plan (the "Plan").

Effective Date: 01/01/2026

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

Adoption of the Plan Document
The Plan Sponsor, as the settler of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). 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.

Carson Tahoe Health Systems.

By: Signed by: Katie Kucera 81C99F5A0F014C5...

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Date: 12/19/2025 | 16:40 PST

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